

2026 OPEN ENROLLMENT BENEFITS GUIDE

Making the Most of Benefits



If you and/or your dependent have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Review our plan's Medicare Part D creditable coverage disclosure included in this brochure in the Important Notices section.

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WELCOME TO WHIDBEYHEALTH

WhidbeyHealth benefits program gives you choices of benefits and coverage amounts that you can select to craft a package that supports you and your family. We value your contribution to the organization, and we are proud to provide you and your family with this comprehensive program. We view benefits as an important piece of your total compensation.

Our health care plan renews on January 1st every year. Every year we review our benefit plan offerings, consider what we offer, the cost for the year and what we can afford. We consider our levels of benefits, our insurance company performance, and the cost to both you and the company. Based on this review, and in consultation with our benefit consultant, we have made the following decisions for our benefit offerings for this plan year:

- **Medical** benefits will be changing from Premera Blue Cross to a self-funded arrangement with Regence Group Administrator (RGA), utilizing the Regence/Blue Shield network of providers. You will continue to have the option of two plans – a traditional PPO plan and a High-Deductible Health Plan (with a Health Savings Account feature).
- **Dental** benefits will continue to be provided by Delta Dental and Willamette Dental.
- **Vision** benefits will continue to be provided by VSP; frame allowance for featured brand frames has increased by an additional \$50.
- **Life/AD&D, Long Term Disability** will continue to be provided by Symetra.
- You will continue to have the option to buy additional or supplemental **Life Insurance** coverage through Symetra.
- **Health Savings Account** administration will continue to be provided by HealthEquity.
- **Employee Assistance and Provider Assistance Programs** will continue to be offered through FirstChoice.

Please keep in mind that our health plan is self-funded. This means WhidbeyHealth takes on the financial responsibility for paying health care claims, rather than paying an insurance company to do so. While Regence Group Administrators (RGA) handles the processing of your claims, the actual funds used to pay those claims come directly from WhidbeyHealth. Those funds are made up of the premiums contributed by both WhidbeyHealth and you. We're continuing our philosophy of covering the majority of health care premiums for teammates, while also helping with most of the cost of covering dependents.

This summary highlights some of the main features of your benefit package so that you can make informed decisions about the best coverage for you and your family.

ELIGIBILITY REQUIREMENTS

You are considered eligible for benefits if you are an active employee who normally works at least 24 hours per week unless otherwise specified by a Collective Bargaining Agreement. Benefits begin on the first day of the month following your date of hire.

Benefit coverage ends on the last day of the month in which you separate from employment, or if your employment status changes to an ineligible level. You or your covered family members may be eligible for COBRA coverage. Please contact Human Resources for details.

WhidbeyHealth requires an employee to provide documentation to verify their dependents' eligibility. The documents must establish a dependent relationship with you. Example of required documentation to submit to Human Resources may include:

- Marriage certificate
- Legal documents that establish dependent custody,
- Birth certificate
- Tax forms
- Medical documentation of disability
- Adoption papers

ELIGIBLE DEPENDENTS ARE YOUR:

- Legal Spouse
- Registered State Domestic Partner
- Your children until they turn age 26
- Unmarried children over 26 who are in are incapable of self support

ENROLLMENT COMPLETION

If you are a newly eligible for our benefit plans, you have 30 days from your hire date (or date of change to an eligible position) to enroll for benefits. This is your chance to make the following benefit elections (enrollment forms are required for all of the following):

- Eligible family members – decide if you want to cover them
- Enroll in a Healthcare Flexible Spending Account (FSA)
- Purchase additional LTD coverage
- Select your Life Insurance beneficiary

If you are currently enrolled, you may change your elections only during the open enrollment period, which occurs in the month of November each year for a January 1st effective date. The only exception is if you have a qualified family status change during the year.

CHANGING YOUR CHOICES DURING THE YEAR

The benefit choices you make are in effect from your enrollment date through December 31st. You may make changes during the year only if you have a qualified family status change, or if it is during our open enrollment period in November for a January 1st effective date. When you have a life change you must notify HR and have the change forms submitted within 30 days of the change.

OPEN ENROLLMENT

This is the time of year to add or drop coverage for any eligible family members. If you do not enroll an eligible spouse or child now because they have coverage through another employer, you may only add that person on our plan during next year’s Open Enrollment period, unless you experience a qualified family status change. Please refer to the Special Enrollment section later in this document.

QUALIFYING LIFE EVENTS

Once you’re enrolled in benefits, you generally aren’t allowed to make changes until the next annual Open Enrollment. Open Enrollment is your one chance each year to review your coverage and make changes to your benefits. It’s also your chance to enroll if you declined coverage when you first became eligible. Open Enrollment changes take effect on January 1st each year.

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a qualifying status change. Please refer to the Special Enrollment section later in this document.

Some changes (not exhaustive) in family status events are:

Marriage, Divorce or Legal Separation	Birth or Adoption of a Child
Death of a Spouse or Covered Child	Change in a spouse’s work status affecting their benefits
Change in a Child’s eligibility for Benefits	A Qualified Medical Child Support Order

Remember:

You must notify HR and have the change forms submitted with 60 days

ENROLLMENT COMPLETION

The Open Enrollment elections process is online through the **UKG PRO Open Enrollment module** and will be open from **November 10th to November 26th**. Most of your current benefits elections (medical, dental, etc.) will be pre-populated in the system and you will only need to confirm your continued enrollment and election levels in these plans. However, some benefits elections automatically reset to zero each year like the Health Care FSA and Dependent Care FSA elections; so, you will need to specifically designate the amount you wish to set aside in 2026. All benefit elections and changes must be made no later than end of day on **November 26th**.

WHAT DO I HAVE TO DO?

- This is also your opportunity to switch from the Traditional Health Plan (PPO) to the High Directed Health Plan (HDHP), or vice versa.
- Please note that any family members you cover will be enrolled on the same plan as you.
- This is your opportunity to add coverage for your spouse or partner and children who were previously eligible but not enrolled.
- You must complete your enrollment selections online through the **UKG PRO Open Enrollment module**.
- If you wish to drop coverage for yourself or any dependents, now is the time to do so.
- You must make an election for the flexible spending account (Health Care FSA or Dependent/Day Care FSA), if you wish to participate. If you want to make pre-tax deductions to your FSA account, you must make a new election for 2026.
- If you want to make pre-tax deductions to your HSA account, you must complete your election.

ALL ENROLLMENT CHANGES MUST BE COMPLETED THROUGH
UKG PRO OPEN ENROLLMENT MODULE BY NOVEMBER 21st.

WHERE DO I GO IF I HAVE QUESTIONS?

- See page 8 for customer service numbers and websites for the carriers.
- Human Resources – 360-678-8600

BENEFITS ADVOCACY – HERE TO HELP

WhidbeyHealth has also partnered with IMA to provide you and your family with individualized assistance with insurance problems you are unable to resolve directly with the carriers. This includes claims issues, eligibility questions, network problems and general healthcare or insurance questions.



Your Account Manager	Email	Phone
Todd Syvrud, V.P., Senior Account Manager	todd.syvrud@imacorp.com	425-709-3633

HOW MUCH DO I HAVE TO PAY?

The following contributions are effective January 1, 2026.

- Full Benefits and Premium Costs: Assigned .6 FTE & higher unless otherwise specified by a Collective Bargaining Agreement.
- If you are a Partial Benefit Employee, please contact Human Resources for coverage costs.
- Employees assigned to a .5 FTE position, please contact Human Resources for coverage costs.
- Benefits for EMS employees are subject to the terms and conditions of the IAFF CBA.

HDHP (HSA) PLAN			
Per Pay Period Premium	WH Pays Monthly	You Pay Monthly	You Pay Per Pay Period
Employee	\$955.07	\$0.00	\$0.00
Employee & Spouse/ State Registered Domestic Partner*	\$1,551.99	\$596.92	\$298.46
Employee & Child*	\$1,456.49	\$214.89	\$107.45
Employee & Children*	\$1,420.67	\$250.71	\$125.36
Employee & Family*	\$1,910.15	\$955.08	\$477.54

PPO HEALTH PLAN			
Per Pay Period Premium	WH Pays Monthly	You Pay Monthly	You Pay Per Pay Period
Employee	\$1,208.90	\$0.00	\$0.00
Employee & Spouse/ State Registered Domestic Partner*	\$1,904.40	\$815.62	\$407.81
Employee & Child*	\$1,793.12	\$322.47	\$161.24
Employee & Children*	\$1,751.39	\$364.20	\$182.10
Employee & Family*	\$2,321.69	\$1,305.02	\$652.51

DELTA DENTAL			
Per Pay Period Premium	WH Pays Monthly	You Pay Monthly	You Pay Per Pay Period
Employee	\$46.35	\$0.00	\$0.00
Employee & Spouse/ State Registered Domestic Partner*	\$58.80	\$32.36	\$16.18
Employee & Child(ren)*	\$68.15	\$34.70	\$17.35
Employee & Family*	\$86.66	\$60.60	\$30.30

WILLAMETTE DENTAL			
Per Pay Period Premium	WH Pays Monthly	You Pay Monthly	You Pay Per Pay Period
Employee	\$64.25	\$0.00	\$0.00
Employee & Spouse/ State Registered Domestic Partner*	\$89.80	\$38.70	\$19.35
Employee & Child(ren)*	\$89.80	\$38.70	\$19.35
Employee & Family*	\$120.65	\$72.10	\$36.05

VISION SERVICE PLAN (VSP)			
Per Pay Period Premium	WH Pays Monthly	You Pay Monthly	You Pay Per Pay Period
Employee	\$4.00	\$0.00	\$0.00
Employee & Spouse/ State Registered Domestic Partner*	\$5.64	\$2.35	\$1.18
Employee & Child(ren)*	\$6.78	\$1.77	\$0.89
Employee & Family*	\$9.55	\$4.12	\$2.06

* Includes benefits coverage for state registered domestic partners and their children. Due to IRS regulations, contributions for state registered domestic partners are made on a post-tax basis. In addition, any premiums paid by WhidbeyHealth will be considered taxable income.

Please note that when your contributions are taken out of your paycheck on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status.

CONTACT INFORMATION

Refer to this list when you need to contact a benefits vendor. For general information, contact Human Resources.



GROUP NUMBER	VENDOR	PHONE NUMBER	EMAIL OR WEBSITE
Medical	Regence Group Administrators (RGA)	866-738-3924	www.accessrga.com
Pharmacy/Rx Mail Order	CVS Caremark	866-819-6911	www.caremark.com
Virtual Care	Talkspace (All States) AbleTo (WA-OR-ID-UT) Zoom Care (WA-OR-ID)	Behavioral Health Behavioral Health Primary/Urgent/Specialty	www.talkspace.com/partnerinsurance www.ableto.com www.zoomcare.com
Dental (PPO)	Delta Dental of Washington	800-554-1907 833-604-1246 (TEXT)	www.deltadentalwa.com cservice@deltadentalwa.com
Dental (DHMO)	Willamette Dental	855-433-6825	www.willamettedental.com
Vision	Vision Service Plan	800-877-7195	www.vsp.com
Flexible Spending Arrangement (FSA)	HealthEquity	800-924-3967	www.healthequity.com memberservices@healthequity.com
Health Savings Account (HSA)	HealthEquity	866-346-5800	www.healthequity.com memberservices@healthequity.com
Employee Assistance Program (EAP)	First Choice	800-777-1323	www.firstchoice.com Username: whidbeyhealth
Provider Assistance Program (PAP)	First Choice	800-777-1323	www.firstchoice.com Username: whidbeyhealth
Life Insurance, Voluntary Life & Long-Term Disability Insurance	Symetra	877-377-6773	www.Symetra.com
Benefits Advocacy	IMA – Todd Syvrud	425-709-3633	todd.syvrud@imacorp.com
WhidbeyHealth Benefits	Human Resources	360-678-8600	

2026 OPEN ENROLLMENT BENEFIT SUMMARIES

To view the summaries for the benefits mentioned in this guide,
please click on the link below

[WhidbeyHealth - Benefit Summaries for 2026 Open Enrollment](#)

or scan the QR-Code:





Medical - Regence Group Administrators – NEW Medical Plan Administrator

Beginning January 1, 2026, we will change medical administrators from Premera Blue Cross to Regence Group Administrators (RGA). To ensure a smooth transition to RGA, Premera Blue Cross is sending RGA information for approved prior authorizations and members currently engaged with a Care/Case manager. RGA will honor prior authorizations issued by Premera Blue Cross. All employees electing a medical plan will be receiving a new ID card from Regence Administrators. These will be mailed to your home late December 2025.

You have the choice of two medical plans: A High-Deductible Health Plan or HDHP, which includes a Health Savings Account or HSA, and a traditional PPO Plan. NEW THIS YEAR - within each plan there are additional benefits by going to a Whidbey Health Provider or facility. The Network of Providers outside of the Domestic Tier (WhidbeyHealth) are contracted under the national Blue Card Program. This means that any licensed Blue Cross or Blue Shield Provider nationally or globally is considered an in-network provider.

[If you have questions about your plan or want to find an in-network doctor, call RGA's Customer Care Team. They are available to help Monday-Friday 5:00 AM to 6:00 PM at 888-277-3313 beginning November 1, 2025.](#)

Pharmacy – CVS Caremark – NEW Pharmacy Benefit Manager

Beginning January 1, 2026, we will change pharmacy benefit managers from Premera/Express Scripts to CVS/Caremark. To ensure a smooth transition to CVS/Caremark, Express Scripts is sending CVS/Caremark members claim history and prior authorizations so they can be set up in their systems. We expect a CVS/Caremark welcome letter and packet to be mailed to our employees in December introducing them as their new pharmacy partner. Our employees will continue to have the option of filling their prescriptions through our own in-house pharmacies or a network pharmacy.

While we don't anticipate any disruptions during the transition to **CVS Caremark**, some prescriptions may require new approvals or additional steps before they can be filled. To ensure you have what you need, we recommend **refilling your prescriptions before the end of December**. If possible, you may want to request an **extra 30-day supply** to carry you through the month of January while the new program takes effect.

FOLLOWING IS A SUMMARY OF OUR HDHP MEDICAL PLAN WITH HSA

Regence Group Administrators	Whidbey Health Providers/Facilities (Domestic Tier)	In-Network Providers (BlueCross/BlueShield)
Annual Deductible <i>Individual/Maximum per family</i>	\$1,700 Individual / \$3,400 Family (aggregate)*	
Out-of-Pocket Maximum <i>Individual/Maximum per family</i>	\$4,000 Individual / \$8,000 Family (aggregate)**	
Preventive Care Visit	0% deductible waived	0% deductible waived
Physician Services <i>Primary, Specialty, Surgical</i>	10% after deductible	20% after deductible
Outpatient X-Ray & Lab Services	10% after deductible	20% after deductible
<u>Whidbey Health Walk-In Clinic</u> Urgent Care Facilities	10% after deductible	20% after deductible
Emergency Services	10% after deductible	10% after deductible
Hospital Services <i>Inpatient and Outpatient</i>	10% after deductible	20% after deductible
Mental Health Outpatient	10% after deductible	20% after deductible
Spinal Manipulations <i>12 visits per calendar year</i>	10% after deductible	20% after deductible
Outpatient Rehab <i>60 visits per calendar year</i>	10% after deductible	20% after deductible
Hearing Exam & Hardware	Exam: Subject to deductible Hardware: No dollar limit (per ear) every 36 months	
Out of Network (OON) Providers (Balance Billing May Apply) Cost Share		
OON Deductible <i>Individual/Family</i>	Shared with in-network	Shared with in-network
OON Out-of-Pocket Max <i>Individual/Family</i>	Shared with in-network	Shared with in-network
Out-of-Network Coinsurance	40% after deductible	40% after deductible

***Family Aggregate Deductible:** The deductible amount depends on whether you enroll with or without family members. If more than one person is covered on the HDHP, which is an IRS-Qualified High-Deductible Health Plan, the family deductible will need to be satisfied before the Plan starts to make payments for your healthcare costs for any individual (except for services considered Preventive).

****Family Aggregate Out-Of-Pocket Maximum:** For those covering more than one person on the HDHP, one member of the family can meet the entire family out-of-pocket maximum, or several family members can combine out-of-pocket expenses to meet the family out-of-pocket maximum

FOLLOWING IS A SUMMARY OF OUR PPO MEDICAL PLAN

Regence Group Administrators	Whidbey Health Providers/Facilities (Domestic Tier)	In-Network Providers (BlueCross/BlueShield)
Annual Deductible <i>Individual/Maximum per family</i>	\$0 Individual / \$0 Family (Whidbey Health) \$500 Individual / \$1,000 Family (In-Network Providers)	
Out-of-Pocket Maximum <i>Individual/Maximum per family</i>	\$2,500 Individual / \$5,000 Family (WhidbeyHealth or In-Network Providers)	
Preventive Care Visit	0%*	0%*
Physician Services <i>Primary, Specialty, Surgical</i>	\$20 copay*	\$30 copay*
Outpatient X-Ray & Lab Services	10% after deductible	20% after deductible
<u>Whidbey Health Walk-In Clinic</u> Urgent Care Facilities	\$20 copay*	\$30 copay*
Emergency Services	\$250 copay, then 10% after deductible	
Hospital Services <i>Inpatient and Outpatient</i>	10% after deductible	20% after deductible
Mental Health Outpatient	\$20 copay*	\$30 copay*
Spinal Manipulations <i>12 visits per calendar year</i>	\$20 copay*	\$30 copay*
Outpatient Rehab <i>60 visits per calendar year</i>	\$20 copay*	\$30 copay*
Hearing Exam & Hardware	Exam: \$20 copay (WH) / \$30 copay (In-Network Provider) Hardware: No dollar limit (per ear) every 36 months	
Out of Network (OON) Providers (Balance Billing May Apply) Cost Share		
OON Deductible <i>Individual/Family</i>	Shared with in-network limits	Shared with in-network limits
OON Out-of-Pocket Max <i>Individual/Family</i>	Shared with in-network limits	Shared with in-network limits
Out-of-Network Coinsurance	40% after deductible	40% after deductible

* Not subject to annual deductible

**DON'T FORGET YOUR ANNUAL EXAM.
PREVENTIVE CARE IS COVERED 100%**

PHARMACY BENEFITS



CVS/Caremark

This plan requires the use of appropriate generic drugs. When available, a generic drug will be dispensed in place of a brand name drug. If a generic equivalent isn't manufactured, the applicable brand name copay or coinsurance will apply. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug copay or coinsurance.

Our employees will have the option of filling their prescriptions **through our own in-house pharmacy** or an in-network pharmacy (WH | In-Network).

Tiers	HDHP HSA Plan (After Medical Deductible)		500 PPO Plan (Medical Deductible Waived)	
	Retail (30-day supply) WH In-Network	Mail Order (90-day supply) WH In-Network	Retail (30-day supply) WH In-Network	Mail Order (90-day supply) WH In-Network
Generics	10% 20%	10% 20%	\$10 \$30 copay	\$20 \$60 copay
Preferred Brand	10% 20%	10% 20%	\$25 \$75 copay	\$50 \$150 copay
Non-Preferred Brand	10% 20%	10% 20%	\$60 \$180 copay	\$120 \$360 copay
Specialty Drugs	10% 20%	10% 20%	Same as above	Same as above
Notice regarding Medicare Part D	Our medical plans offer what is called "creditable coverage," which means a Medicare-eligible person will not have to buy a Medicare Part D supplement for prescription drugs and will not be subject to the 1% per month late enrollment charge assessed by Medicare for purchasing Part D at a later date. If you have questions about your options, please contact Human Resources.			

NETWORK EXTENDERS: DIGITAL BEHAVIORAL HEALTH PROVIDERS

The following **digital only** offerings are an extension of your provider network.

Providers	Focus	Offering	Get Started
	General Mental Health*	Talkspace offers a range of virtual mental health treatment options to choose from, including online therapy, coaching, self-help tools, psychotherapy, and medication management. For members ages 13 and older.	Register at www.talkspace.com/partnerinsurance State(s) Available: All 50 States
	Obsessive Compulsive Disorder (OCD)	NOCD provides therapy for OCD through live sessions with a licensed, specialized therapist. For members ages 6 and older.	Visit: www.nocd.com Call: (312) 766-6780 State(s) Available: WA, OR, ID, UT
Boulder	Substance Use Disorders: • Opioid Use Disorder (OUD) • Alcohol Use Disorder (AUD)	Boulder care offers virtual treatment for substance use disorders, including medication-assisted treatment, peer coaching, care coordination and other recovery tools. For members ages 18 and older.	Visit: start.boulder.care Call: (866) 347-9635 State(s) Available: WA, OR, ID, UT
	General Mental Health*	AbleTo Therapy+ provides mental health care through an eight-week online therapy program. Sessions are one-to-one with a licensed therapist, and digital tools give you extra support. For members ages 18 and older.	Visit: www.ableto.com Call: (866) 287-1802 State(s) Available: WA, OR, ID, UT

*General mental health may include stress, anxiety, depression, eating disorders, substance use, sleep, identity struggles, chronic issues, trauma and grief, relationships, healthy living.



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NETWORK EXTENDERS: DIGITAL & IN-PERSON PROVIDERS

In-patient and residential treatment may require a prior-authorization.

Providers	Focus	Offering	Get Started*
 eleanor health	- Substance Use Disorder - General Mental Health	Eleanor Health provides virtual and in-person support including medication-assisted treatment, psychiatry, therapy and counseling, and recovery coaching. For members ages 18 and older.	Call 1-866-323-2596 or visit www.eleanorhealth.com State(s) Available: WA
charlie health	- Trauma - Substance Use Disorder - LBTQ Support - Intensive Outpatient - Dialectical Behavioral Therapy	Charlie Health offers virtual and in-person intensive outpatient treatment. For members ages 12-30.	Call 1-866-540-1828 or visit www.charliehealth.com State(s) Available: WA, OR, ID, UT
 Hazelden Betty Ford Foundation	- Substance Use Disorder - Mental Health Treatment	Hazelden Betty Ford offers in-person and virtual therapy, high-intensity outpatient programs and medication-assisted treatment. For members ages 18 and older.	Call 1-877-361-9611 or visit www.hazeldenbettyford.org State(s) Available: WA, OR
zoomcare	- Primary Care - Urgent Care - Specialty Care	Zoomcare offers same day video or in-person options in select metro markets. Website and app available for members ages 13 and older.	Visit www.zoomcare.com/schedule or download the iOS or Android App State(s) Available: WA, OR, ID
dispatchhealth	- Urgent Care - House Calls	DispatchHealth provides urgent care house calls 7 days/week. For members ages 3 months and older.	Visit www.dispatchhealth.com State(s) Available: WA

*May not be available in all state counties. Standard deductibles and copay apply. CharlieHealth, Eleanor Health, Hazelden Betty Ford, Zoomcare, and DispatchHealth are separate companies.



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MEMBER DEALS AND DISCOUNTS

As an RGA member, you have access to many discounts on programs, products, and services to help support you and your family's health and well-being.

Allergy Relief Products

20% off products for non-drug allergy relief (such as pillows, air filters, cleaning products, and personal care products) from National Allergy Supply.

Fitbit Product Store

Save on Fitbit devices, accessories, and Fitbit Premium.

Fitness Discounts

Access a gym membership as low as \$28 per month through Active&Fit Direct that includes digital on-demand workouts too.

Funeral Planning Service

\$50 off the enrollment fee for Everest suite of funeral planning services

Hearing Aids

Discounts on hearing aids through TruHearing and Amplifon.

Meal Planning Services

Complimentary shipping (\$14.95 value), fresh-made meals prepared for yourself or your loved one with Mom's Meals NourishCare®.

Pet Wellness Plans

No enrollment fee for Optimum Wellness Plans at Banfield Pet Hospitals (inside PetSmart).

Student Loan Refinancing

Comprehensive solution to help borrowers reduce their debt by refinancing and consolidating their student loans.

Vision Care & LASIK

Save on laser vision correction, contact lenses, and eyeglasses with QualSight LASIK, and Zenni Optical.

Walgreens Smart Saving

Access 20% smart saver discount on eligible Walgreens brand over-the-counter health and wellness products.

How to access your deals and discounts

How to access your deals and discounts

1

Log in to the RGA Member Portal

2

Select "Explore Your Benefits"

3

Select "Health & Wellness Discounts"

The deals and discounts are provided by separate companies to RGA members. These companies do not provide BlueCross BlueShield products or services and are solely responsible for their product or services.



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DENTAL COVERAGE – Delta Dental of Washington



Contracted providers agree to bill Delta Dental of Washington directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Delta Dental. You may be responsible for any additional amounts (also called balance billing). The deductible and annual maximum are on a calendar-year basis and reset every January 1st.

To find a list of in-network providers, call 800-554-1907 or visit www.deltadental.wa.com and click on Online tools. Use the "Find a Dentist" tool and search in the Delta Dental PPO Plus Premier Network.

	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON- PARTICIPATING DENTIST
	WHAT YOU PAY		
Calendar Year Deductible	\$50 Individual \$150 Family		
Class I – Preventive Care (Deductible Waived) (Oral Exams, Cleanings, X-rays, Sealants, Fluoride Treatment)	Covered in Full	20%	20%
AFTER DEDUCTIBLE, YOU PAY			
Class II – Restorative (Fillings, Extractions, Oral Surgery, Periodontics)	20%	30%	30%
Class III – Major (Crowns, Bridges, Dentures, Implants)	50%	60%	60%
PLAN MAXIMUMS			
Calendar Year Maximum per Individual	\$1,750		
Orthodontia Services, per Individual	Covered at 50% up to \$1,750 lifetime		

We encourage you to go online and register at Delta Dental of Washington's website which gives you access to eligibility, claims, cost treatment, exam reminders, and ability to print your ID card.

Registering and accessing the website is easy. After your coverage effective date for dental:

- Visit www.deltadental.wa.com
- If you have created a user-name and password, enter that information and click "sign in" If not click on "Register Now". You will need your member ID from your ID card (or social security number).
- Once you have signed in, you will have access to the MySmile dashboard.

DENTAL COVERAGE - Willamette Dental



Dental coverage through Willamette Dental will also be offered. You must obtain your dental care through a Willamette Dental Clinic which are located throughout Washington. To locate the nearest office go to locations.willamettedental.com and enter your zip code. You can also contact Willamette customer service at 855-433-6825.

	WILLAMETTE DENTAL PLAN
Office Visit	\$5 copay
Preventive Care Exams Cleanings Periodontal Exams Fluoride Treatments X-rays Sealants (per tooth)	Covered with office visit copay
Restorative Fillings Porcelain-Metal Crown	\$10-\$50 copay \$100-\$175 copay
Prosthodontics Complete Upper or Lower Denture Bridge (per Tooth)	\$140 copay \$125-\$175
Endodontics and Periodontics Root Canal Therapy-Anterior Root Canal Therapy-Bicuspid Root Canal Therapy-Molar Osseous Surgery (per Quadrant) Root Planning (per Quadrant)	\$100 copay \$125 copay \$150 copay \$75-\$100 copay \$15-\$35 copay
Oral Surgery Routine Extraction (Single tooth) Surgical Extraction	\$10 copay \$10-\$50 copay
Orthodontia Pre-Orthodontia Treatment Comprehensive Orthodontia Treatment	\$150 copay \$1,500 copay
Calendar Year Maximum per Individual	No Maximum
Orthodontia Services, per Individual Adults Children	\$2,000 \$1,600

VISION COVERAGE – Vision Service Plan (VSP)

We offer very comprehensive vision benefits that include coverage for routine vision exams, glasses, and contact lenses. To get the best benefits, you must use the services of a VSP provider. To find a VSP provider, call 800-877-7195 or go to www.vsp.com

- Use the **Find a Doctor** tool on the right side of the landing page
- Enter your zip code
- Hit **Search**

Once you select the VSP provider you wish to see, make an appointment and they take care of the rest.

You are not required to use a VSP provider as we do provide benefits for those that are out of network, but you will pay more. You do have the flexibility to use a non-VSP provider for your exam and a VSP provider for your glasses or contact lenses. Expenses incurred with a non-VSP provider can be submitted easily online through your individual VSP account.

	VSP PROVIDERS	NON-VSP PROVIDER
Well Vision Exam Every 12 months	\$20 copay	Paid up to \$45 allowance
Frames Every 24 months	\$150 allowance for standard frames, \$220 allowance for featured brands and 20% discount on amounts over the allowance \$80 allowance at Costco/Walmart	Paid up to \$70 allowance
Eyeglass Lenses – every 24 months Single Vision Lined Bifocals Lined Trifocals	\$20 copay (combined with exam copay)	Paid up to \$30 allowance Paid up to \$50 allowance Paid up to \$65 allowance
Lens Enhancements Polycarbonate Lenses Scratch-resistance Coating Standard Progressives Premium Progressives Custom Progressives Discount for other lens enhancements	Paid in full (children only) Paid in full 100% after \$55 copay 100% after \$95 to \$105 copay 100% after \$150 to \$175 copay 20 to 25%	No additional benefit No additional benefit Paid up to \$50 allowance Paid up to \$50 allowance Paid up to \$50 allowance None
Contacts	\$150 allowance plus copay for contact lens exam/fitting of up to \$60	Paid up to \$105 allowance
Extras	LightCare benefit – you can use your frame and lens benefit to get non-prescription sunglasses or blue light filtering glasses. Extra glasses and sunglasses with 20% savings from any VSP provider within 12 months of your well vision exam. Retinal Screenings with a copay of no more than \$39 as an enhancement to a well vision exam. Laser vision correction with average 15% discount off regular price or 5% off promotional price; only available from VSP contracted facilities.	None

FLEXIBLE SPENDING ARRANGEMENTS – Health Equity

Health Care FSA

A Healthcare Flexible Spending Account (FSA) provides you with an important tax advantage that can help you pay health care expenses on a pre-tax basis. By anticipating your family's health care costs for the next year, you can actually lower your taxable income. On January 1st of each year, or when you are first eligible, you may choose to have money taken out of your paycheck pre-tax to cover eligible health care expenses.

This program allows you to set aside up to **\$3,400** so that you can pay for certain IRS-approved medical care expenses not covered by the insurance plan with pre-tax dollars. Some examples include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Chiropractic services
- Prescription copays
- Dental services and orthodontia

For a complete list of eligible and non-eligible expenses the IRS will allow you to use your FSA dollars for, visit Health Equity's website at www.healthequity.com/fsa-gme

The great thing about the healthcare FSA is that your entire election is available to you on your effective date, or the first day of the plan year. So you can use your debit card, or submit claims, for your whole election and it will be funded upfront, with deductions coming out of your paycheck in equal amounts over the course of the year.

IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment.

How do I get the funds of my FSA?

Everyone who signs up for a healthcare FSA will be sent a debit card that has been pre-filled with your annual election. You can use it to pay for eligible out of pocket healthcare expenses, but Health Equity may ask that you substantiate your card use if the service is not a usual copay amount. The IRS has a list of what you can and cannot use your FSA funds for, and Health Equity is required to make sure you are using them for IRS approved expenses. Save your receipts and explanation of benefit statements, because they will let you know if you need to send in proof that your service was OK with the IRS.

If you don't wish to use your Debit Card, or if you need to substantiate your debit card use, you can submit claims online, through Health Equity's smartphone app for Android and iPhone, or you can download a claim form from the Health Equity website and email, fax or mail. Claims are typically processed within a few days and reimbursements are issued either by check or direct deposit (if elected).

You or your family members do not have to be enrolled in the medical plan to take advantage of the FSA. You can use your FSA dollars to pay for any eligible out of pocket medical expense for any of your eligible family members. Eligible family members include your spouse and tax dependents.

CAN I CHANGE HOW MUCH I PUT INTO MY ACCOUNT DURING THE YEAR?

Only if you experience a change in family status (marriage, birth/adoption, divorce, etc.), otherwise the IRS won't allow it.

Due to IRS guidelines, those participating on an HSA plan are not eligible for this FSA option.

While you should only set aside enough money for those expenses you know you will incur during the plan year, the roll-over provision allows you to carry forward up to \$680 into the next plan year.



FLEXIBLE SPENDING ARRANGEMENTS – Health Equity

Dependent Care FSA

Like the Health Care FSA, you may also use pre-tax dollars to pay for qualified dependent care. Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be so you can work, actively look for work or be a full-time student. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house Nursery schools and preschools (excluding kindergarten)

The annual maximum amount you may contribute into the Dependent/Day Care FSA is **\$7,500** per calendar year (or **\$3,750** if married and filing separately).

This limit is set by the IRS and is a calendar year limit. Dependent Care only has funds available as you contribute, it is not front loaded at the beginning of the plan year.

Unlike the Healthcare FSA, the Dependent Care FSA is a true "use it or lose it" account. Be careful what you choose to set aside for daycare, reimbursements as any leftover funds cannot be rolled over to the next year.

Enrollment in the Dependent Care FSA is not impacted by which medical plan you enroll in, or if you waived medical coverage entirely.

Note: Election changes are also allowed when there is a change in cost or coverage of your childcare provider.



2026 HSA Contributions

When you are enrolled in the medical base plan with HSA, WhidbeyHealth will contribute **\$850 for employee coverage** or **\$1,700 for family coverage** to each employee's account annually (contributions are made on bi-weekly basis). Employees who become eligible for the benefit within the year will receive a prorated amount. Additionally, you may elect to make additional contributions to your HSA from your paycheck on a tax-free basis.

Health Savings Accounts

You must be enrolled in the HDHP Plan to take advantage of the HSA.

If you enroll in the Qualified High-Deductible Health Plan (QHDHP), then you may be eligible to open a Health Savings Account (HSA). An HSA is a tax-advantaged savings account (administered by Health Equity) that belongs to you and is designed to help you save money pre-tax for when you have higher health care expenses.

Regardless of who puts money into your HSA, HSA dollars are owned by you, the account holder. Unused money rolls over to the next year and is fully portable. This means you take it with you if you change jobs or retire.

A Health Savings Accounts (HSA) is a tax-advantaged savings account that belongs to you and is designed to help you save money pre-tax for when you have higher health care expenses. Regardless of who puts money into your HSA, HSA dollars are owned by you, the account holder. Unused money rolls over to the next year and is fully portable. This means you take it with you if you leave.

The maximum amount you can contribute to your HSA (from all sources, which includes WhidbeyHealth's HSA employer contributions) is determined annually by the IRS.

- **FOR 2026:** Individual only Coverage: \$4,400
- **FOR 2026:** Individual, plus one or more covered family members: \$8,750
- Additional catch-up contribution for those 55+: \$1,000



DUE TO IRS GUIDELINES, THOSE ELECTING A HEALTH SAVINGS ACCOUNT ARE NOT ELIGIBLE FOR A HEALTH FLEXIBLE SPENDING ACCOUNT.

It is your responsibility to confirm you are eligible to receive contributions to your Health Savings Account.

To receive contributions, you must NOT have other health coverage for yourself including:

- Coverage through an individual non-qualified HDHP plan
- Coverage through a spouse's or parent's non-qualified HDHP plan
- Access to a spouse's Flexible Spending Arrangement Be a dependent on someone else's tax return
- Coverage through a state or federal program:
 - Tricare/Champva/Veterans Administration
 - Native/Tribal plan
 - Medicare
 - Medicaid

LIFE AND AD&D INSURANCE - Symetra

WhidbeyHealth pays for Life and AD&D benefits for employees who work at least 20 hours per week. Employees receive a \$50,000 benefit.

Benefits

\$50,000. If death is the result of an accident (as defined by the contract), then the beneficiary(ies) will receive an additional 100%. A scheduled benefit is paid for amputation or paralysis of limbs.

Supplemental Life/AD&D Insurance

If you want additional group life insurance, you may purchase additional amounts through payroll deductions. You must be enrolled in supplemental life to purchase life insurance for your spouse or child.

REMINDER: IF YOU RECENTLY HAD CHANGE A FAMILY STATUS, THIS IS A GOOD TIME TO UPDATE YOUR BENEFICIARY INFORMATION.

	EMPLOYEE	SPOUSE	CHILD(REN)
Increments	\$10,000	\$5,000	Flat \$10,000
Maximum	Five times salary not to exceed \$500,000	\$250,000 not to exceed 50% of Supplemental Employee Coverage	\$10,000 Benefit limited to \$250 from birth to 6 months.
Guaranteed Amount*	\$150,000	\$25,000	\$10,000

*Guaranteed Amount is only available when first eligible and all other elections require Evidence of Insurability (EOI).

Supplemental Life premiums are based on your age and change the first pay period after your birthday if you are aging into a higher age bracket.

Supplemental Life/AD&D Rates per \$1,000 of monthly coverage:

AGE BAND	EMPLOYEE/ SPOUSE RATE PER \$1,000	CHILD RATE PER \$1,000
Under age 25	\$ 0.028	\$ 0.124
25 – 29	\$ 0.031	The premium paid for child coverage is based on the cost of one child, regardless of how many children you have.
30 – 34	\$ 0.034	
35 – 39	\$ 0.043	
40 – 44	\$ 0.064	
45 – 49	\$ 0.092	
50 – 54	\$ 0.143	
55 – 59	\$ 0.268	
60 – 64	\$ 0.411	
65 – 69	\$0.758	
70 – 74	\$1.131	
75 and over	\$1.131	
Supplemental AD&D		
	\$0.019	\$0.016

LONG-TERM DISABILITY (LTD) - Symetra

WhidbeyHealth pays for long-term disability benefits for employees who work at least 20 hours per week. LTD provides income replacement in the event you are not able to work due to an accident or illness. Benefits begin once you are totally disabled for 180 days or more, meet the definition of disability and are under the care of a physician.

LTD Base Plan (Employer Paid)

LTD Payment Begins	180 days from disability
Monthly Benefit	50% of your basic monthly earnings to a maximum of \$2,000 per month
Duration	If your disability occurs before age 60, you will receive benefits until age 65 as long as you continue to meet the definition of disability, and you are under the care of a licensed physician. Benefits are limited for those whose disability begins age 60 or after.
Definition of Disability	For the first 24 months of disability, you are unable to do all substantial and material duties of your own occupation and have at least 20% loss of earnings due to the disabling condition. Thereafter, you are unable to perform the duties of ANY occupation for which you are qualified by education, training or experience, and have at least a 40% loss of earnings.
Pre-Existing Condition Limitation	The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage. A pre-existing condition is defined as: a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the 3 months prior to your effective date of coverage.

LTD Buy-Up Options (Employee Paid)

Should you wish to buy-up to a higher level of LTD coverage, you have two options illustrated below. These options allow you to lower the elimination period or increase the benefit amount.

LTD Payment Begins	
Buy-Up Option #1	<u>90 days</u> from disability
Buy-Up Option #2	<u>180 days</u> from disability
Monthly Benefit	<u>60%</u> of your basic monthly earnings to a maximum of <u>\$6,000</u> per month
Calculating Your Cost	
Buy-Up Option #1	$\$0.733 \times \text{your monthly earnings} / 100 = \text{Monthly Buy-Up cost}$
Buy-Up Option #2	$\$0.544 \times \text{your monthly earnings} / 100 = \text{Monthly Buy-Up cost}$

Please refer to our Symetra benefit summaries and contracts for the full description of what is covered, at what level and what is excluded from our LTD plans. LTD benefits will be offset by earnings you may receive from other sources such as social security, workers' compensation, etc.

EMPLOYEE WELLBEING



EMPLOYEE ASSISTANCE PROGRAM

First Choice EAP is here to coach and guide you through the challenges in your life.

Whidbey Health's complimentary EAP program is available 24/7 and covers employees, spouses, domestic partners, and children up to age 26. The EAP is here to help when you're facing issues that interfere with your health, well-being, and productivity at home or at work.

The EAP offers up to 5 sessions face-to-face or telehealth (no copay, deductible, or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. 30-minute legal and financial expert consultations and 60-minute ID theft resolutions are available at no cost. EAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer and can save you thousands.

Accessing our EAP is easy!
Simply call them at
800-777-4114 to request
a free, confidential
appointment — available
24/7

Access their library of
resources online at
FirstChoiceEAP.com
and enter our Username:
WhidbeyHealthEAP

PROVIDER ASSISTANCE PROGRAM (Physicians & CMS)

Whidbey Health's complimentary PAP Program through First Choice is available 24/7 and covers physician providers, spouses, domestic partners, and children up to age 26. The PAP is here to help you when you're facing issues that interfere with your health, well-being, and productivity at home or at work.

The PAP offers up to 5 sessions face-to-face or telehealth (no copay, deductible, or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. 30-minute legal and financial expert consultations and 60-minute ID theft resolutions are available at no cost. PAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer and can save you thousands when buying or selling a home.

Call the Provider Assistance
Program at 800-777-1323 to
request a free, confidential
appointment — available
24/7

Access their library of
resources online at
FirstChoiceDOC.com
and enter our Username:
WhidbeyHealthEAP

WASHINGTON PAID AND FAMILY MEDICAL LEAVE

Paid Family and Medical Leave provides paid time off when a serious health condition prevents you from working, when you need to care for a family member or a new child, or for certain military-related events. It's here for you when you need it most, so you can focus on what matters.

Nearly every Washington worker—whether you work full time or part time in a small to large business—is eligible for up to 12 weeks of Paid Family and Medical Leave. You need to work 820 hours in Washington, or about 16 hours per week, over the course of about a year. You can get up to 16 weeks if you have family and medical events in the same year, or up to 18 weeks in some cases. You may apply for leave with the Employment Security Department to receive partial wage replacement, up to 90 percent of your typical pay, capped in 2026 at \$1,647 per week. The program is funded by premiums shared between workers and employers.

If you have questions or need more information about Washington PFML, please visit paidleave.wa.gov or email paidleave@esd.wa.gov, or call 833-717-2273.



ANNUAL HEALTH PLAN IMPORTANT NOTICES

TABLE OF CONTENTS

CMS Part D Notice of Creditable or Non-Creditable Prescription Drug Coverage

Informs the individual as to whether their current prescription drug coverage is creditable, which means that the coverage is expected to pay on average as much as standard Medicare prescription drug coverage. Accordingly, this information is essential to an individual's decision whether to enroll in a Medicare Part D prescription drug plan.

Special Enrollment Rights

Describes how an employee eligible for the group health plan may be entitled to special enrollment rights outside of the Company's open enrollment period, such as for certain losses of prior coverage or the addition of a new dependent.

HIPAA Notice of Privacy

Describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

General Information about How to Continue Health Coverage

Informs the individual of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event, and other available coverage options such as through the Marketplace.

Women's Health and Cancer Rights Act

Informs participants about benefits covering mastectomies and related services and how to get detailed information on available benefits.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

Informs employees about possible State financial assistance for health insurance coverage.

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

NOTICE: CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare’s prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain “creditable” coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
HDHP HSA Plan	None
500 PPO Plan	None

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at <https://www.shiphelp.org>.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2026
Name of Entity/Sender: Whidbey Health
Contact—Position/Office: Justin Williams, Sr. HR Business Partner
Address: 101 N. Main Street, Coupeville, WA 98239
Phone Number: 360-678-7656 x6559

NOTICE: SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	You have the right ❖ Get a copy of your health and claims records ❖ Correct your health and claims records ❖ Request confidential communication ❖ Ask us to limit the information we share ❖ Get a list of those with whom we've shared your information ❖ Choose someone to act for you ❖ File a complaint if you believe your privacy rights have been violated
Your Choices	You have some choices in the way that we use and share information as we: ❖ Answer coverage questions from your family and friends ❖ Provide disaster relief ❖ Market our services and sell your information
Our Uses and Disclosures	We may use and share your information as we: ❖ Help manage the health care treatment you receive ❖ Run our organization ❖ Pay for your health services ❖ Help with public health and safety issues ❖ Do research ❖ Comply with the law ❖ Respond to organ and tissue donation requests and work with a medical examiner or funeral director ❖ Address workers' compensation, law enforcement and other government requests ❖ Respond to lawsuits and legal action

Your Rights	When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	❖ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ❖ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	❖ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. ❖ We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	❖ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ❖ We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	❖ You can ask us not to use or share certain health information for treatment, payment or our operations. ❖ We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of those with whom we’ve shared information	❖ You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. ❖ We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	❖ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	❖ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ❖ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	❖ You can complain if you feel we have violated your rights by contacting us using the information on page 9. ❖ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ❖ We will not retaliate against you for filing a complaint.
Your Choices	For certain health information, you can tell us your choices about what to share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:	❖ Share information with your family, close friends, or others involved in payment for your care ❖ Share information in a disaster relief situation <i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i>

In these cases, we never share your information unless you give us written permission:	❖ Marketing purposes ❖ Sale of your information	
Our Uses and Disclosures	How do we typically use or share your health information. We typically use or share your health information in the following ways.	
Help manage the health care treatment you receive	❖ We can use your health information and share it with professionals who are treating you.	Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	❖ We can use and disclose your information to run our organization and contact you when necessary. ❖ We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	❖ We can use and disclose your health information as we pay for your health services.	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your Plan	❖ We may disclose your health information to your health plan sponsor for plan administration.	Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [Your Rights Under HIPAA | HHS.gov](#).

Help with public health and safety issues	We can share health information about you for certain situations such as: ❖ Preventing disease ❖ Helping with product recalls ❖ Reporting adverse reactions to medications ❖ Reporting suspected abuse, neglect or domestic partner violence ❖ Preventing or reducing a serious threat to anyone's health or safety
Do research	❖ We can use or share your information for health research

Comply with the law	❖ We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	❖ We can share health information about you with organ procurement organizations. ❖ We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: ❖ For workers' compensation claims ❖ For law enforcement purposes or with a law enforcement official ❖ With health oversight agencies for activities authorized by law ❖ For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	❖ We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- ❖ We are required by law to maintain the privacy and security of your protected health information.
- ❖ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ❖ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ❖ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [Your Rights Under HIPAA | HHS.gov](#).

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

If you recently gained coverage under a group health plan (the Plan), this notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work (for fully insured plans issued in California, coverage generally last for 36 months). Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the end of these notices. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or

visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31,, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: (855) 692-5447	Health First Colorado Website: https://healthfirstcolorado.com/ Health First Colorado Member Contact Center: (800) 221-3943 / State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: (800) 359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: (855) 692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: (866) 251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: Website: https://health.alaska.gov/dpa/Pages/default.aspx	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: (877) 357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: (855) MyARHIPP (855-692-7447)	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: (678) 564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: (916) 445-8322 Fax: (916) 440-5676 Email: hipp@dhcs.ca.gov	Healthy Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: (800) 403-0864 Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)	MASSACHUSETTS – Medicaid and CHIP
MEDICAID WEBSITE: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562e: (888) 346-9562	Website: https://www.mass.gov/masshealth/pa Phone: (800) 862-4840 TTY: 711 Email: masspremassistance@accenture.com
KANSAS – Medicaid	MINNESOTA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: (800) 792-4884 HIPP Phone: (800) 967-4660	Website: https://mn.gov/dhs/health-care-coverage/ Phone: (800) 657-3672
KENTUCKY – Medicaid	MISSOURI – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: (855) 459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: (877) 524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005
LOUISIANA – Medicaid	MONTANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Medicaid Hotline: (888) 342-6207 LAHIPP Phone: (855) 618-5488	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: (800) 694-3084 Email: HSHIPPProgram@mt.gov
MAINE – Medicaid	NEBRASKA – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: (800) 442-6003 TTY: Maine Relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: (800) 977-6740 TTY: Maine Relay 711	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA – Medicaid	OREGON – Medicaid
Website: https://dhcfp.nv.gov/ Phone: (800) 992-0900	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: (800) 699-9075
NEW HAMPSHIRE – Medicaid	PENNSYLVANIA – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: (603) 271-5218 Toll free number for the HIPP program: (800) 852-3345 Ext. 5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: (800) 692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) Phone: (800) 986-KIDS (5437)

NEW JERSEY – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (800) 356-1561 CHIP Premium Assistance Phone: (609) 631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710 (TTY: 711)	Website: http://www.eohhs.ri.gov/ Phone: (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)
NEW YORK – Medicaid	SOUTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: (800) 541-2831	Website: https://www.scdhhs.gov Phone: (888) 549-0820
NORTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: (919) 855-4100	Website: http://dss.sd.gov Phone: (888) 828-0059
NORTH DAKOTA – Medicaid	TEXAS – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: (844) 854-4825	Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: (800) 440-0493
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: (888) 365-3742	Utah's Premium Partnership for Health Insurance (UPP) Medicaid Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: (888) 222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: http://health.utah.gov/chip
VERMONT– Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: (800) 250-8427	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: (304) 558-1700 CHIP Toll-Free Phone: (855) MyWVHIP (699-8447)
VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid & CHIP Phone: (800) 432-5924	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: (800) 362-3002
WASHINGTON – Medicaid	WYOMING – Medicaid
Website: https://www.hca.wa.gov/ Phone: (800) 562-3022	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on *Special Enrollment Rights*, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565