Your Benefits

Effective December 1, 2021

WACBD

WELCOME TO YOUR BENEFITS!

We are proud to offer a robust benefits package to our employees and their families! Our benefits package is designed around choice, flexibility and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. If you have general questions on your benefits or how to enroll, reach out to Human Resources or a Gallagher Benefit Advocate—their contact info is toward the back of this Guide under "*Your Benefits Contacts*."

In addition, a Summary of Benefits and Coverage (SBC) has been provided to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act. Additional copies are also available, free of charge. Please contact Human Resources to request a copy.

When Open Enrollment wraps, we'll provide detailed booklets on each plan element you chose. But for now, check out this guide and online resources, and begin benefitting!

IMPORTANT:
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 13 for more details.

WHAT'S INSIDE:

BENEFITS OVERVIEW

BENEFIT PLANS :

- Premera Medical insurance covering a broad network of doctors and prescriptions
- Dental Insurance
- Vision Insurance
- Life and accidental death & dismemberment insurance
- Long term disability insurance
- Employee assistance program (EAP)
- Employee paid voluntary life

COST

The amount you pay depends upon which plans you elect and which dependents you choose to enroll. This table shows how benefit costs are shared. Costs for coverage of domestic partners and their children might not be deducted on a pre-tax basis. If your domestic partner is not an eligible tax dependent as defined in Section 152 of the Internal Revenue Code, then a portion of your contribution will be deducted after-tax and the company's contribution for domestic partner coverage will be taxable income to you and reported as imputed income on your pay check. For more information, please contact Human Resources.

	Total Monthly Cost	WIFC Cost	Employee Cost
Medical - HSA $1500 Plan			
Employee Age 21 and Over	$673.37	$673.37	$0.00
Employee Under Age 21	$293.62	$293.62	$0.00
Dependent Age 21 and Over	$673.37	$336.69	$336.69
Dependent Under Age 21	$293.62	$146.81	$146.81
Medical - PPO $1500 Plan			
Employee Age 21 and Over	$713.19	$713.19	$0.00
Employee Under Age 21	$310.98	$310.98	$0.00
Dependent Age 21 and Over	$713.19	$356.60	$356.60
Dependent Under Age 21	$310.98	$155.49	$155.49
Dental - Delta Dental Core			
Employee	$29.55	$29.55	$0.00
Employee & Spouse	$59.20	$29.55	$29.65
Employee & Child(ren)	$74.25	$29.55	$44.70
Employee and Family	$103.85	$29.55	$74.30
Dental - Delta Dental Buy-Up			
Employee	$60.30	$60.30	$0.00
Employee & Spouse	$120.60	$60.30	$60.30
Employee & Child(ren)	$146.10	$60.30	$85.80
Employee and Family	$206.35	$60.30	$146.05
Vision - VSP			
Employee	$8.63	$8.63	$0.00
Employee & Spouse	$13.81	$8.63	$5.18
Employee & Child(ren)	$14.10	$8.63	$5.47
Employee and Family	$22.73	$8.63	$14.10

MEDICAL BENEFITS - PREMERA BLUE CROSS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The plan provides excellent coverage of preventive services that are very important to you and your family's health.

Your cost share will be:

PCY = Per Calendar Year (January 1-December 31)	HSA $1,500		PPO $1500	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (individual/Family)*	$1,500/ $3,000	$3,000/ $6,000	$1,500/ $3,000	$3,000/ $6,000
What You Pay	20%	50%	20%	50%
Annual Out-of-Pocket Maximum † (Individual/Family)*	$3,900/ $7,800	Unlimited Unlimited	$6,500/ $13,000	Unlimited Unlimited
Preventive Care	No charge	50% after deductible	No charge	50% after deductible
Outpatient Services				
Primary Care Visit	20% after deductible	50% after deductible	1st 2 visits covered in full, then $20 copay	50% after deductible
Specialist Visit	20% after deductible	50% after deductible	$50 copay	50% after deductible
Diagnostic Lab & X-Ray	20% after deductible	50% after deductible	20% deductible waived	50% after deductible
Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Rehabilitation	20% after deductible 25 visits combined PCY	50% after deductible	$50 copay 25 visits combined PCY	50% after deductible
Other Services				
Chiropractic Care	20% after deductible 10 visits combined PCY	50% after deductible	$20 copay 10 visits combined PCY	50% after deductible
Acupuncture	20% after deductible 12 visits combined PCY	50% after deductible	$20 copay 12 visits combined PCY	50% after deductible
Urgent Care	20% after deductible	50% after deductible	$50 copay	50% after deductible
Emergency Room (copay waived if admitted)	20% after deductible		$200 copay + 20% after deductible	
Inpatient Hospitalization	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Prescription Drug Plan	**At Participating Pharmacies After Deductible**		**At Participating Pharmacies**	
Retail Pharmacy (30-day supply)				
Preferred Generic	20%		$20 copay	
Generic	Specific Generic Preventive - Covered in Full		Not applicable	
Preferred Brand	20%		$50 copay	
Brand	20%		Non-preferred - $80 copay	
Preferred Specialty	20%		Not applicable	
Specialty (30-day supply only)	20%		25%	
Mail Order (90-day supply)	20%		3x retail cost share	
Formulary	M-1		M-4	

* The HSA plan has an aggregate annual deductible. Therefore, if enrolled as anything other than an employee, the family deductible must be met prior to receiving other plan benefits.
The HSA plan has an aggregate annual out-of-pocket maximum. Therefore, if enrolled as anything other than an employee, the family out-of-pocket maximum must be met prior to receiving other plan benefits.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

For Premera and Select Carriers only
IMPORTANT! Premera Blue Cross requires prior authorization to receive coverage for certain planned services. If prior authorization is not obtained for a required service, you will be subject to additional cost shares not outlined here. A complete list of services requiring prior authorization is available at www.Premera.com.

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

If you enroll in the High Deductible Health Plan (HDHP), then you may be eligible to open an HSA. An HSA is a bank account where you can set aside money to pay for expenses that your health plan does not cover. The money in your HSA is not considered income, so it is not subject to taxes.

HOW DOES AN HSA WORK?

You can use the money in your HSA at any time to pay for eligible medical expenses.

When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received.

Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan.

You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

WHO CAN OPEN AN HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

- You must be covered by a qualified high-deductible health plan.
- You must not be enrolled in or covered by Medicare or Tricare.
- You must not be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non HSA-qualified health plan.
- You must not be claimed as a tax dependent on another person's taxes.
- You have not received any Veteran's Administration health benefits for a non-service connected disability in the last three months.
- You have not used Indian Health Services coverage in the last three months.

SPECIAL NOTES ON HSA'S AND DOMESTIC PARTNERS:

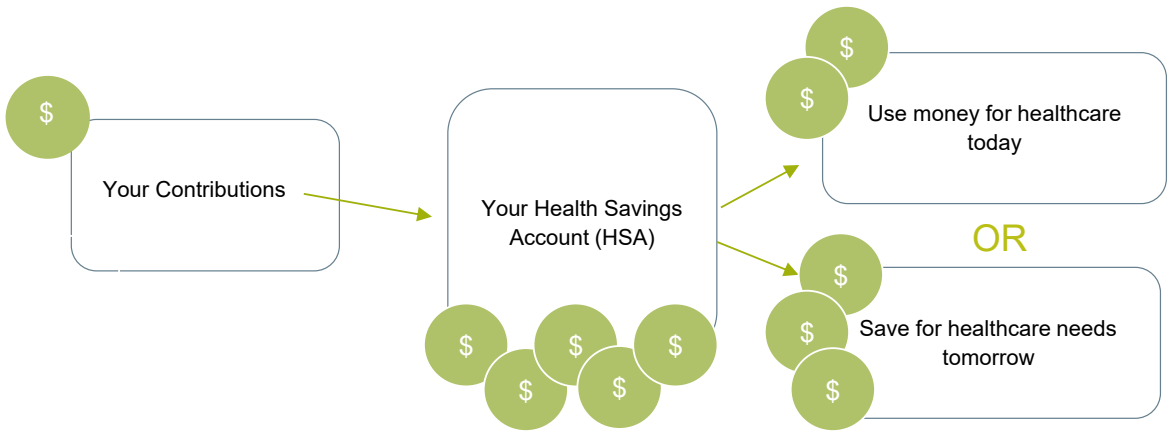
- Domestic partners are eligible to be enrolled in an HDHP plan;
- Distributions from the HSA are only allowed if your domestic partner is an IRS qualified tax dependent. Consult your tax advisor for details.

CONTRIBUTIONS

Employee and employer combined contributions cannot exceed $3,650 (individual) or $7,300 (family) in 2022.

For individuals age 55 or older, an additional $1,000 in "catch-up" contributions are allowed for 2022.

Your money rolls over every year. There is no "use it or lose it" rule.



IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT

NON-NETWORK COSTS

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

ORGAN TRANSPLANT

Organ and bone marrow transplants have a $7,500 travel and lodging maximum. Organ and bone marrow transplants are subject to a six (6) month waiting period after your effective date. After six (6) months, the waiting period for transplants is no longer applicable. If it is less than six (6) months, the waiting period can be shortened with prior creditable coverage. Please see your plan contract booklet for further details.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and co-insurance amounts.

OUT-OF-AREA BENEFITS

If you are traveling or living outside of Washington and need medical care, you may use a Blue Cross or BlueShield PPO provider to receive the same benefits as the preferred level of your plan. When you are outside of the service area and need medical care, call the BlueCard Access Line a t800.810.BLUE (2583) for information on the nearest PPO doctors and hospitals. The doctor or hospital will verify your membership and coverage information after you present your identification/membership card. The doctor or hospital will electronically route your claim to your Blue Cross plan for processing. Because all PPO providers are paid by the plan directly, you are not required to pay for the care at time of service and then wait for reimbursement. You will only need to pay for out-of-pocket expenses, such as non-covered services, deductible, copays and co-insurance.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

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 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN *(CONTINUED)*

HIPAA Notice of Privacy Practices Reminder

HIPAA requires your employer to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of WIFC's Privacy Notice or for additional information, please contact Human Resources.

PATIENT PROTECTION DISCLOSURE NOTICE

WIFC's Premera medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Premera listed under "*Your Benefits Contacts*" on the last page of this Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Premera or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Premera listed under "*Your Benefits Contacts*" in the back of this Guide.

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. A list of these preventive services can be found on the HHS website at: healthcare.gov/preventive-care-benefits.

HEALTHCARE REFORM & YOUR BENEFITS

WIFC offers a medical plan option that provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

DENTAL BENEFITS - DELTA DENTAL OF WASHINGTON

Oral care is very important to your health and general well being. Under this plan, you may access dental care services from any licensed dentist you wish. However, if you obtain services from a preferred provider, you will save money on your out-of-pocket expenses.

	Options Core		Options Buy-Up	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$50 per person		$50 per person	
(waived for Preventive & Diagnostic)	$150 per family		$150 per family	
Annual Benefit Maximum	$750 per person		$1,500 per person	
Waiting Period	None		None	
Services				
Preventive & Diagnostic	No charge	No charge	No charge	No charge
Basic	50% after deductible	50% after deductible	20% after deductible	20% after deductible
Major	Not Covered	Not Covered	50% after deductible	50% after deductible
Periodontics	Covered under basic		Covered under basic	
Endodontics	Covered under basic		Covered under basic	
Implants	Not Covered		Covered under major	
Orthodontia (Adults and Children)				
Services	Not Covered		50%	50%
Lifetime Benefit Maximum	Not Covered		$1,500 per person	

Late Enrollment Penalty: The effective date of coverage for late entrants will be the next plan anniversary date.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

MAXIMUM ALLOWABLE FEE

When you use out-of-network services, your plan will pay a percentage of the maximum allowable fee. If your dentist charges more than the maximum allowable fee, you will be responsible for the difference.

VISION BENEFITS - VSP

We are happy to offer vision coverage to help you take care of your eyesight. You may choose to obtain your vision care services from any provider you wish. When you access care from network providers, your benefits are greater and your out-of-pocket costs are less.

	In-Network	Out-of-Network Reimbursed
Routine Exam	$10 per visit	Up to $50*
Materials Copay	$25 copay	$25 copay
Lenses		
Single Vision	No charge*	Up to $50*
Lined Bifocals	No charge*	Up to $75*
Lined Trifocals	No charge*	Up to $100*
Frames	$150 then 20% discount	Up to $70*
Contact Lenses (in lieu of eyeglasses)		
Fitting and Evaluation	15% but no more than $60	Up to $105 for services and materials
Elective Contacts	$150 allowance	Up to $105 for services and materials
Frequency (Exam/Lenses/Frames)	12/12/12 Months	

*Less any applicable copay

If you purchase oversize lenses or have anything “special” done to your lenses (i.e., tinting, scratch guard, etc.), you will be responsible for this cost.

IMPORTANT

Not all lenses are paid in full; some have additional features. Be sure to ask your provider if your choice is covered in full.

- Discuss your lens options with your provider
- Confirm that your lens options are paid in full by your plan
- If not, confirm with your provider whether or not you want to continue with their recommendations for lens options

LIFE AND LTD BENEFITS - UNUM

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

To help you protect your family, we offer and fully pay for basic life and accident insurance.

	Life/AD&D
Benefit Amount	
Life Insurance	$50,000
Accidental Death & Dismemberment	$50,000
Benefits Begin to Reduce at Age:	65

WHEN YOU FIRST ENROLL

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary designation at any time.

LONG TERM DISABILITY (LTD) COVERAGE

When you cannot work for an extended period of time, an LTD plan can help cover a portion of your pre-disability earnings.

	Long Term Disability
Monthly Benefit Amount	60% of Base Monthly Earnings
Maximum Monthly Benefit	$6,000
Elimination Period	90 days
Benefit Duration	SSNRA
Definition of Disability	Own Occupation for 24 months
Employee Assistance Program	Included

IMPORTANT

Restrictions and limitations apply to these benefits. Please review the insurance booklet or certificate for complete details.

Note: If you are located in an area that offers disability coverage or has a paid leave program, it may impact the benefit yo u receive under our coverage. For specific benefit coverage information, please contact the carrier.

VOLUNTARY BENEFITS - UNUM

You have the option to buy additional voluntary insurance through payroll deduction. You may purchase these voluntary benefits when you are initially benefit eligible or during open enrollment.

Voluntary Life – Benefit Outline	
Benefit Options	
Employee	$10,000 Increments
Spouse	$5,000 Increments
Children (6 months to 19, or 26 if FT student)	$2,000 Increments
Infant (14 days to 6 months)	$1,000
Benefit Maximums	
Employee	Lesser of 5x annual salary or $500,000
Spouse	Lesser of 100% of employee benefit amount or $250,000
Children (6 months to 19, or 26 if FT student)	$10,000
Infant (14 days to 6 months)	$1,000
Guarantee Issue	
Employee	$50,000
Spouse	$15,000
Children (6 months to 19, or 26 if FT student)	$10,000
Infant (14 days to 6 months)	$1,000
Benefits Begin to Reduce at Age:	70
Waiver of Premium	Included
Portability	Included

Please see the benefit summary for additional plan details.

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 **1-877-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 **1-866-444-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 January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

California – Medicaid
Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1.800.359.1991/State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1.877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1.800.403.0864

IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-6185488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1.800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1.800.862.4840

MINNESOTA – Medicaid
Websitehttps://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/medical-assistance.jsp
Phone: 1.800.657.3739

MISSOURI – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

CHIP (*CONTINUED*)

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603.271.5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1.800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1.888.365.3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1.800.699.9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical /HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347 , or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1.888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1.888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1.800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1.800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/hipp/
Medicaid Phone: 1.800.432.5924
CHIP Phone: 1.855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1.800.562.3022

WEST VIRGINIA – Medicaid
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

WISCONSIN – Medicaid and CHIP
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 1.800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of
Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323
(Menu Option 4, Ext. 61565)

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM WIFC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with WIFC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Your company has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN AN MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with WIFC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE *(CONTINUED)*

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through WIFC changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Date: December 1, 2021
Name of Entity: WIFC
Contact-Nicole Jobson
Address: 701 Pike Street Suite 1900 Seattle WA 98101
Phone Number: 206-292-6507

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

You have a right to continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you under the Plan (see your plan document or summary plan description for more detail), you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

Benefit Advocates (a service provided by Gallagher), are available to provide confidential, free help with your insurance nee ds.

Please do not include any confidential or sensitive information, such as social security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

Benefit	Administrator	Group Number	Contact Information		Website
Medical	Premera Blue Cross		Customer Service	800.722.1471	Premera.com
Dental	Delta Dental of Washington		Customer Service	800.554.1907	DeltaDentalWa.com
Vision	Vision Service Plan		Customer Service	800.877.7195	VSP.com
Life/AD&D, and LTD	UNUM		Life/AD&D Claims	800.455.0402	UNUM.com
			Disability Claims	877.851.7637	
			Portability/Conversion	800.343.5406	
Employee Assistance Program	HealthAdvocate			800.854.1446	

PLEASE NOTE:

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.

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