



2026 Benefits Guide

LIGHTHOUSE MISSION MINISTRIES

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

LIGHTHOUSE MISSION MINISTRIES

Welcome to the 2026 Benefits Overview!



Medical



Life & Disability



EAP



Value Add Plans



Resources

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

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

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

Look for this icon throughout the Guide for important information!



2026 Plan Changes

Premera Plan Changes

- **SB 5213 Prescription Drug Mandate**
 - Outpatient Prescriptions: No mandatory mail order or specialty pharmacy requirements. Member may choose any in-network mail order or specialty pharmacy. Equivalent 90-day retail and mail order prices—90-day prescriptions can be filled at any in-network pharmacy at the same price as mail order. Retail/mail orders must have the same cost shares.
 - Mail order copays are all set at 3x's retail. This means the Tier 2 mail order copay will change from \$79 to \$105.
- **State Mandate — Clarification on Hearing Aids**
 - Hardware dollar limit removed. The benefit will now cover one device per ear with hearing loss, every 36 months; covered in full — deductible and coinsurance apply to HSA plans.
- **State Mandate — Clarification on Diagnostic Mammography & Supplemental Breast Exams**
 - Covered in full on HSA plans.

BENEFITS RESOURCE CENTER

Check out our NEW Benefits Resource Center!

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

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



WELLNESS RESOURCE CENTER

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

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



MEDICAL / Premera Blue Cross



Prime Network

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

IN-NETWORK BENEFITS	WCIF 5000
Deductible (Ded) Individual Family	\$5,000 \$10,000
Coinsurance (Coins)	0%
Out-of-pocket max (includes copay and deductible) Individual Family	\$5,000 \$10,000
Office Visit (OV)	\$35 Copay
Preventive Care	Covered in Full
Manipulations (spinal) 20 visits Per Calendar Year	\$35 Copay
Diagnostic Lab and X-ray Services Some services may require pre-authorization	Deductible
Inpatient Hospital	Deductible
Outpatient Surgery Facility	\$75 Copay; Deductible
Emergency Care Copay (copay waived if admitted)	\$200 Copay; Deductible
Bariatric Surgery (\$25,000 Lifetime Maximum)	Covered as Any Other Service
Hearing Hardware (1 device / per ear / 36 months)	Covered in Full

New member ID cards will be issued in January 2026.

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



SCAN CODE to view the
Summary of Benefits and
Coverage!





Prescription Drug Coverage

Your medical insurance includes comprehensive prescription drug coverage. The level of coverage depends on whether the drug is generic or brand name, and whether it is on the Premera formulary, or preferred drug list. Your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand name drugs that are not on the formulary. To find out if your medication is on the formulary, [SCAN CODE below](#).

When filling a prescription, present your Premera member ID card to any participating pharmacy. Out-of-Network pharmacy is not covered under the WCIF plans.

PRESCRIPTION DRUGS	PPO Plans except HSA Plans
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Retail Cost Shares	\$5/\$35/\$70
Mail Cost Shares	\$15/\$105/\$210
Day Supply	Retail: 90 Days / Mail: 90 Days / Specialty: 30 Days
Individual Deductible PCY	No Individual Deductible
Family Deductible PCY	No Family Deductible
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

Lower your prescription drug costs today!

Rx Savings Solutions is a benefit that helps you and others on your health plan easily find the lowest-price options for prescription drugs.

1. Check out what **lower-cost prescriptions** may be available and compare prices at different pharmacies.
2. **Rx Savings Solutions will handle everything** with your doctor and pharmacy to switch to a lower-cost pharmacy.
3. You'll receive an email (or text message) any time you can spend less, **taking the burden off you** to find the lowest price!

Activate your account at myrxss.com/premera or scan this QR code:



So simple. So easy.



SCAN CODE to find out if your medication is on the formulary!



Basic Life & AD&D / The Standard



Basic Life & AD&D

Employer-paid life insurance is an important working benefit. It provides your loved ones with a little additional income if you pass away. It helps serve as a financial safety net during the most crucial income earning years. Your employer maintains a Basic Life/AD&D Plan for you that provides **a 1x Annual Salary up to \$100K benefit.**

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

Beneficiary Designation

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



SCAN THIS CODE
FOR MORE INFO!



Base LTD / The Standard



Base Plan
provided to
employees
enrolled in
medical

Base Long Term Disability (LTD)

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

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

Guarantee issue coverage only applies during the initial eligibility period.



SCAN THIS CODE
FOR MORE INFO!



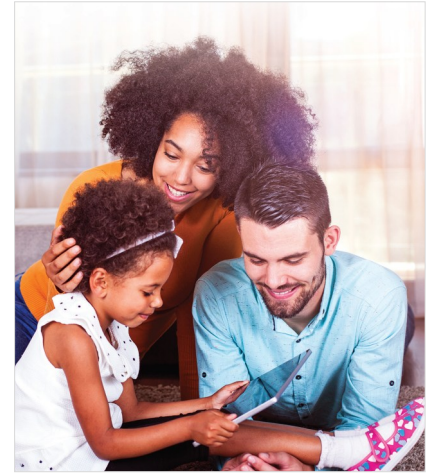


EAP (Employee Assistance Program)

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

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

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



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

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

CONFIDENTIAL SERVICES

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

LEGAL CONSULTATIONS

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

Employment related concerns are not covered.

FINANCIAL SERVICES

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

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

IDENTITY THEFT CONSULTATIONS

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

CHILDCARE REFERRALS

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



ELDERCARE SERVICES

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

HOME OWNERSHIP PROGRAM

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



24/7 Online Access to EAP Services



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

fch.personaladvantage.com

Enter username:

WCIF

(800) 777-4114



24/7 TELEHEALTH

Convenient, private virtual therapy. Anytime, Anywhere.

Talk with a licensed, professional therapist online to get advice, guidance and counseling.



It's professional.

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

It's convenient.

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

It's free to get started.

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

HERE'S HOW IT WORKS:

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



VALUE ADD PLAN – PET INSURANCE / MetLife

Available to all employees



Plan Highlights



What is Pet Insurance?

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

Why MetLife Pet Insurance?

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

How much will it cost?

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

Coverage includes:

accidental injuries
illnesses
exam fees
surgeries
medications
ultrasounds
hospital stays
X-rays and diagnostic

hip dysplasia
hereditary conditions
congenital conditions
holistic care
chronic conditions
alternative therapies
and much more!

Can I still use my vet?

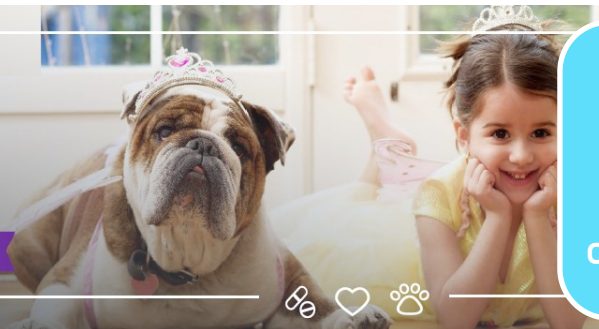
Yes! You can visit any U.S. licensed vet, emergency clinic, or specialist. Your coverage is also portable—you can take your coverage with you if you leave your employer.

SCAN THIS CODE FOR MORE INFO!



If he's always down to play dress up,

he deserves to be insured.



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

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





Available to all employees

Check out BenefitHub for everyday savings!

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

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



Ride in style with **auto** savings.



Travel to new destinations.



Spruce up your **home** and treat the fam.



Look stylish with new **apparel**.



Experience more with event **tickets**.



See you how much you can save!

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



RESOURCES

Dependent Eligibility

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

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

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

Enrollment Changes for Qualified Life Events

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

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



RESOURCES

Waiver of Medical Coverage

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

Group coverage can be:

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

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

Beneficiary Designation

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

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



RESOURCES

MEDICAL / Premera Blue Cross

premera.com | 1.877.500.9247 (customer service)
1.800.841.8343 (24-hour nurseline)

CLAIMS ADDRESS

PO Box 91059
Seattle WA, 98111

PRESCRIPTION DRUG CLAIMS

Express Scripts, Attn: Commercial Claims
PO Box 14711
Lexington KY, 40512



Create an Account

Everything you need to get the most out of your health plan is right at your fingertips at premera.com

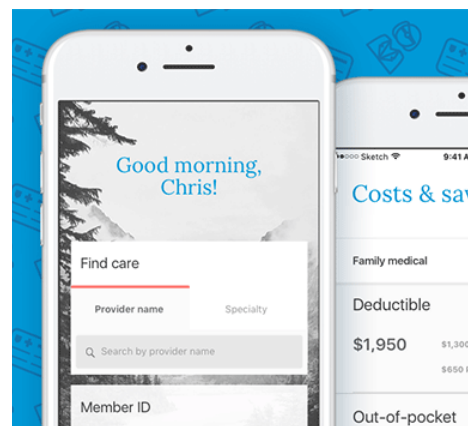
- Estimate the cost of certain treatments.
- Manage and order your prescriptions.
- Track claims and plan spending activity.
- Use the Find a Doctor tool to locate in-network healthcare providers.

Get started by setting up your account online. **You will need your Premera ID card.** Go to premera.com and select the **Log In** button, then select **Create Account**.

Premera Mobile App

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

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



In-Person Visit:

1. Go to <http://www.premera.com/>
2. Click "FIND CARE" at the top of the screen, then "FIND A DOCTOR."
3. Fill in as much information as possible to narrow the search with the network.
 - A. *Be sure to select the correct network: Heritage PLUS or Heritage PRIME*
4. Click "START SEARCH".

Virtual Visit:

1. Go to <http://www.premera.com/>
2. Click "FIND CARE" at the top of the screen, then "VIRTUAL CARE."
3. Select which form of virtual care you are interested in.
4. Create an Account.



RESOURCES

MEDICAL / Premera Blue Cross

[premera.com](https://www.premera.com) | **1.877.500.9247 (customer service)**
1.800.841.8343 (24-hour nurseline)

CLAIMS ADDRESS
PO Box 91059
Seattle WA, 98111

PRESCRIPTION DRUG CLAIMS
Express Scripts, Attn: Commercial Claims
PO Box 14711
Lexington KY, 40512



Online Features & Virtual Care

Virtual care gives members immediate and convenient access to care whenever and wherever they need it. You can avoid any drive times and wait times you might experience at an urgent care center or emergency room. Members who are covered by this service receive care virtually from their own doctor (if available) or from a doctor with one of Premera's contracted vendors for virtual care.

Find out more and connect to the virtual providers below via the Premera mobile app or at [premera.com](https://www.premera.com)

Primary/urgent care + mental health

98point6

Video and text-based primary/urgent care from a doctor

Spring Health

Video and phone based mental health therapy

Talkspace

Mental health therapy via messaging and live video

Substance use disorder

Boulder Care*

Treatment for opioid use disorder and alcohol use disorder. Includes video visits and messaging with a clinician and dedicated peer coach support

Workit Health*

Treatment for opioid use disorder and alcohol use disorder. Includes video visits and messaging with a clinician, online group therapy, and self-led evidence based trainings

NEW! Health & Wellness Discount Program

Blue365

Offers year-round discounts on gym memberships, fitness gear, hearing aids, prescription glasses, healthy eating options and more

*Services provided by Boulder Care and Workit, including medically assisted treatment (MAT) is dependent on a member's location. Contact Premera for more information.



RESOURCES

Life, Disability / The Standard

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

POLICY NUMBERS **Basic Life:** 645273-G **LTD:** 645273-F



Travel Assistance

assistamerica.com | 1.800.872.1414 (customer service)

medservices@assistamerica.com (email)

01-AA-STD-5201

(Travel assist reference number)



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

Contact Travel Assistance

800.872.1414

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

Everywhere else:

+1.609.986.1234

Text:

1.609.334.0807

Email:

medservices@assistamerica.com

REFERENCE NUMBER:

01-AA-STD-5201



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



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



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



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



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

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



RESOURCES

Portability / The Standard



Portability & Conversion

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

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

Portability

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

Conversion – Life

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

Conversion – Disability

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

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

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

or Conversion, please work with your statement on the forms, which are



RESOURCES

Life Services Toolkit / The Standard



Resources and Tools to Support you and your Beneficiary

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

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

Services to Help You Now

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

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

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

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

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

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

If you are a recipient of an Accelerated Benefit¹, you may access the services for beneficiaries.

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

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

Services for Your Beneficiary

Life Insurance beneficiaries² can access services for 12 months after the beneficiary receives the Life claim letter. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

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

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

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

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

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

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



RESOURCES

Employee Assistance Program (EAP / First Choice Health)

firstchoicceap.com

1.800.777.4114 (customer service) | eap@fchn.com

 **First Choice Health**

Employee Assistance Program

ONLINE EAP SERVICES

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

fch.personaladvantage.com

Enter username:

WCIF



(800) 777-4114



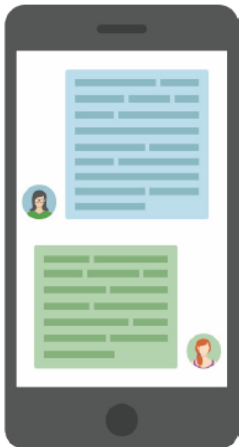
24/7 Telehealth with Talkspace

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

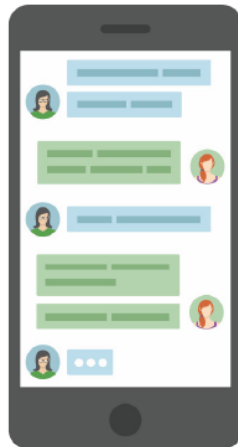


There are four communication methods available:

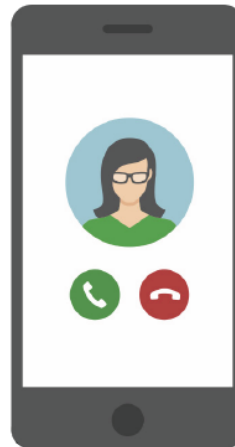
Messaging
(Unscheduled)



Live Chat
(Scheduled)



Live Phone
(Scheduled)



Live Video
(Scheduled)



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



RESOURCES

GLOSSARY OF HEALTH COVERAGE & MEDICAL TERMS

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

Allowed Amount

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

Formulary

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

Balance Billing

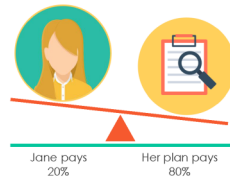
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered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

Network

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

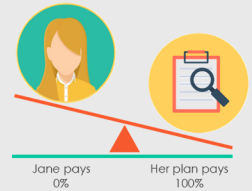
Coinsurance

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



Out-of-pocket Limit

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



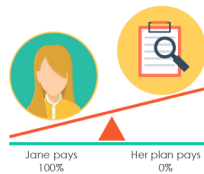
After you meet this limit, the **plan** will usually pay 100% of the **allowed amount**. This limit helps you plan for health care costs. This limit never includes your **premium**, your **balance-billed charges**, or health care your **health insurance** or plan doesn't cover. Some health insurance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

Copayment

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

Deductible

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



Preferred Provider

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



REQUIRED ANNUAL NOTIFICATIONS

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

If you or a covered family member are, or will soon become Medicare Part D eligible, please read this notice carefully and keep it with your records. This notice has information about your current prescription drug coverage with Washington Counties Insurance Fund (WCIF) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare Prescription Drug Plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The carriers have determined that the prescription drug coverage offered by **Washington Counties Insurance Fund** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is **considered creditable coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens to your Current Coverage If You Decide to Join a Medicare Drug Plan?

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

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

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You can continue your existing coverage and choose not to enroll in a Part D plan. However, please know that if you drop or lose your coverage with WCIF and don't enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay more (a penalty) to enroll in a Medicare prescription drug coverage later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may be consistently at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information about This Notice or Your Current Prescription Drug Coverage:

For further information, call the Customer Service number of the back of your ID card. You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare drug coverage and if your current coverage through WCIF should change. You also may request a paper copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. When you become Medicare eligible, you will be mailed a copy of the handbook every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

REQUIRED ANNUAL NOTIFICATIONS

For more information about Medicare prescription drug plans:

- Visit [MEDICARE.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800.MEDICARE (1.800.633.4227)
- TTY users should call 1.877.486.2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information about this extra help, visit Social Security online at [SOCIALSECURITY.gov](https://www.socialsecurity.gov), or by phone at 1.800.772.1213 (TTY 1.800.325.0778).

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

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

Women’s Health and Cancer Rights Act of 1998

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema

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

HIPAA / GINA

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

REQUIRED ANNUAL NOTIFICATIONS

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

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

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

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

How Can I Get More Information? Please visit [WAHEALTHPLANFINDER.org](https://www.wahealthplanfinder.org) or [HEALTHCARE.gov](https://www.healthcare.gov) for more information.

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [HEALTHCARE.gov](https://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1.877.KIDS NOW (1.877.543.7669)** or [INSUREKIDSNOW.gov](https://www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

U.S. Department of Labor
Employee Benefits Security Administration
[www.DOL.gov/agencies/ebsa](https://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](https://www.cms.hhs.gov)
1.877.267.2323, Menu Option 4, Ext. 61565

REQUIRED ANNUAL NOTIFICATIONS

Notice of Special Enrollment Rights

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

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

Loss of Other Coverage

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

New Dependent

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

State Medical Assistance and Children's Health Insurance Program (CHIP)

If you meet any of the following scenarios, you and your dependents may be able to enroll in WCIF health plans within 60 days if:

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

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

*or *Qualified Domestic Partner*

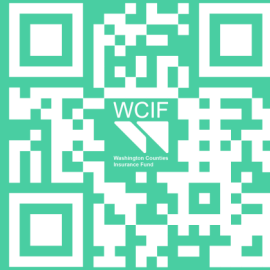
**or *Qualified Domestic Partnership*

Newborns' and Mothers' Health Protection Act of 1996

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

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

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



QUESTIONS?

Contact your Human Resource Department or visit WCIF.net

800.344.8570 (toll free)

info@wcif.net

2620 RW Johnson Blvd SW Suite 300, Tumwater, WA 98512

Benefits are what we do BEST!