2022 BENEFITS ENROLLMENT GUIDE FOR:

Douglas County Sewer District No. 1

This benefit overview is a summary of your benefits as an eligible employee. It is intended to provide a brief description of 2022 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. 2022 documents will be posted as they are approved by respective carriers.

WCIF
WASHINGTON COUNTIES
INSURANCE FUND

DOUGLAS COUNTY SEWER DISTRICT NO. 1

Welcome to the 2022 Benefit Overview!

Open Enrollment is your annual opportunity as an employee to make thoughtful benefit elections for you and your family for the upcoming year. During this time members may change plans, add or remove dependents to existing plans, enroll in a new line of coverage and terminate an existing line of coverage. All open enrollment plan changes will be effective January 1, 2022.

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, otherwise you will have to wait until the next open enrollment period unless you have a qualifying event.

Dependent Eligibility

The following dependents are eligible for coverage after they have satisfied the initial wait 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.

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.

Members are only eligible for guarantee issue coverage in life and disability plans within their first 31 days of benefit eligibility. Members who do not enroll within the guarantee issue period and decide to enroll at a later date will be subject to medical underwriting. Applications received after the first 31 days of eligibility or applicants requesting more than the guarantee issue limits must submit a Medical History Statement and be approved by the carrier before coverage becomes effective. Please review each benefit for specifics under your plan.

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 *or* within 31 days of the date of completed Affidavit of Domestic Partnership
Dependent of Spouse / Domestic Partner	*If existing dependent*, same rules as spouse/domestic partner (31 days – as shown above)
	If acquired *after* 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

2022 Plan Changes

Premera Blue Cross Virtual Care Benefit — Virtual care visits will now be charged the office visit (OV) copay for any virtual care provider.

MEDICAL / PREMERA BLUE CROSS

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

Please note: The highlight summary below shows in-network benefits only. For Out-of-network benefits, please refer to the WCIF Website / Employees / Plan Information / Premera.

Prime Network

IN-NETWORK BENEFITS	WCIF 1250	WCIF 3000	WCIF HSA 1500
Deductible (Ded) **Individual** **Family**	$1,250 $2,500	$3,000 $6,000	$1,500 Aggregate Family: $3,000
Coinsurance (Coins)	20%	20%	20%
Out-of-pocket max (includes copay and deductible) **Individual** **Family**	$6,350 $12,700	$6,350 $12,700	$3,400 Aggregate Family: $6,750
Office Visit (OV)	$35 Copay	$35 Copay	Ded / Coins
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Virtual Care Visits with contracted primary care vendors	Same as OV Copay	Same as OV Copay	Ded / Coins
Manipulations (spinal) 20 visits Per Calendar Year	$35 Copay	$35 Copay	Ded / Coins
Diagnostic Lab and X-ray Services Some services may require pre-authorization	Ded / Coins	Ded / Coins	Ded / Coins
Inpatient Hospital	Ded / Coins	Ded / Coins	Ded / Coins
Outpatient Surgery Facility	$75 Copay; Ded / Coins	$75 Copay; Ded / Coins	Ded / Coins
Emergency Care Copay (copay waived if admitted)	$200 Copay; Ded / Coins	$200 Copay; Ded / Coins	Ded / Coins
Hearing Benefit **1 Exam Per Calendar Year**	$35 Copay	$35 Copay	Ded / Coins
Hearing Benefit **Hardware**	Covered in Full up to $3,000 every 3 Calendar Years	Covered in Full up to $3,000 every 3 Calendar Years	Ded / Coins $3,000 every 3 Calendar Years
Pharmacy 30 day supply	Premera Formulary - Preferred B3	Premera Formulary - Preferred B3	Premera Formulary - Open A1
Generic – Tier 1	$5 Copay	$5 Copay	Ded / Coins
Brand Name – Tier 2	$35 Copay	$35 Copay	Ded / Coins
Non-Preferred – Tier 3	$70 Copay	$70 Copay	Ded / Coins

Premera will issue new ID cards for all enrollees effective January 1, 2022

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 under Employee / Plan Information / Premera

MEDICAL / PREMERA BLUE CROSS

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

HSA Plan—Preventive

PV Core Drug List

These drugs are covered in full for HSA qualifying plans and some large group commercial PPO plans. Please contact customer service to see if your plan qualifies.

LIST OF DRUGS

Ace Inhibitors (hypertension)
benazepril
captopril
enalapril
fosinopril
lisinopril
moexipril
perindopril
quinapril
ramipril
trandolapril

Angiotensin II Receptor Blockers (hypertension)
candesartan
eprosartan
irbesartan
losartan
olmesartan
telmisartan
valsartan

Antiarrhythmic Agents
sotalol

Blood Thinning Agents
aspirin/dipyridamole
clopidogrel
prasugrel
warfarin

Beta Blockers (hypertension)
acebutolol
atenolol
betaxolol
bisoprolol
carvedilol
carvedilol ER
labetalol
metoprolol succinate
metoprolol tartrate
nadolol
pindolol
propranolol
propranolol ER
timolol

Cholesterol Lowering Agents
atorvastatin
cholestyramine
cholestyramine light
colesevelam
colestipol
ezetimibe
ezetimibe/simvastatin
fenofibrate
fenofibric acid
fenofibric acid DR
fluvastatin
fluvastatin ER
gemfibrozil
lovastatin
omega-3 acid ethyl esters
pravastatin
rosuvastatin
simvastatin

Antidiabetic Agents (diabetes)
glimepiride
glipizide
glipizide ER
glipizide XL
glipizide/metformin
glyburide
glyburide micronized
glyburide/metformin
metformin
metformin ER
pioglitazone
pioglitazone/glimepiride
pioglitazone/metformin

Osteoporosis Therapy
alendronate
ibandronate
risedronate
risedronate DR

Antidepressants
citalopram
escitalopram
fluoxetine
fluoxetine DR
fluvoxamine
fluvoxamine ER
paroxetine
paroxetine CR
paroxetine ER
sertraline

Inhaled Corticosteroids (asthma)
Arnuity Ellipta
budesonide inhaled suspension
Flovent Diskus
Flovent HFA
Qvar
Qvar Redihaler

Insulin Therapy (diabetes)
Novolin 70/30
Novolin N
Novolin R
Novolog Mix 70-30

This is not a complete list of medications covered under your plan. This list represents certain generic and brand medications that are covered in full for HSA-qualified and some larger commercial PPO plans and is subject to change without prior notification. If you have questions about your pharmacy benefit, please visit Premera.com/MyPharmacyPlus. If you don't have access to our website, please call the customer service number listed on the back of your ID card.

MEDICAL / PREMERA BLUE CROSS

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

Virtual Care Options

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.

Major Benefit Categories	Benefit "Bucket"	Cost Share
Primary/Urgent Care *(includes Dermatology)*	Virtual Care Only using Premera virtual care vendors	Follows standard professional cost shares just like in person visits
Primary/Urgent Care *(includes Dermatology)*	Traditional Providers *(e.g. Everett Clinic, Virginia Mason, etc.)*	Follows standard professional cost shares just like in person visits
Mental Health	Virtual Care Only – Mental Health	Mental Health outpatient office visit cost shares apply
Substance Abuse/ Chemical Dependency	Virtual Care Only – Chemical Dependency	Chemical Dependency outpatient office visit cost shares apply

Find out more and connect to the virtual providers below via the Premera mobile app or at premera.com

98point6

- A text-based telehealth option where members can connect with a primary care physician from the My Care app when it is most convenient to them.

dr. on demand

- Doctor on Demand is an all-in-one technology and services platform enabling next-generation care. This telehealth option connects members with medical professionals through video communications. Doctor on Demand can be used for physical and internal medicine as well as dermatology and mental health.

talkspace

- Talkspace provides members the ability to easily connect to behavioral therapists and psychiatrists by video and text.

Boulder

- Boulder is a digital care provider, offering long-term support and medication-based treatment for opioid use disorder (OUD), alcohol use disorder (AUD), and common co-occurring conditions for members 18 years and older.

Workit Health

- Workit is a digital care provider offering support for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD). Via Workit web and phone apps, members age 18 and older have a "recovery in their pocket" harm reduction and sobriety solution that provides 24/7 access to interactive therapeutic courses, online support groups supervised by licensed care teams, and weekly 1:1 sessions with licensed counselors specializing in addiction treatment.

Need care? Know where to go — and what it will cost

If you need care but your doctor isn't available, you have options. Some options are more expensive than others. The exact cost of your visit depends on your medical plan and the care you get.

24-Hour Nurseline / FREE

Call the 24-hour nurseline listed on your medical insurance ID card—for free. The nurse can discuss your symptoms and help you find a doctor, urgent care clinic, or hospital near you.

Virtual Care / $

Members have the option of using a variety of virtual care providers. Please refer to your insurance carrier for specific virtual care options for your selected plan..

Urgent Care / $$

Urgent care clinics provide care for illnesses like ear infections, fever or flu symptoms, or sprains. Clinics are often open outside of normal business hours and are less expensive than the emergency room.

Emergency Room / $$$

Emergency room visits cost the most and should be used only for emergencies, such as severe abdominal pain, shortness of breath, sudden numbness, loss of consciousness, or broken bones. Most facilities are open 24 hours per day, 7 days a week (including holidays).

REMINDERS...

1. Prescription drug formularies are reviewed on an ongoing basis and are subject to change with limited notice to members.
2. Some services require prior authorization. Members should make sure their provider requests an authorization in advance for certain services. This pre-service, or prospective review, must be completed before the service is rendered. If the member uses an in-network provider, the provider is responsible for the prior authorization. If the member uses an out-of-network provider, it is the member's responsibility to make sure their doctor requests the prior authorization.
3. In addition to the normal prior authorizations, there may be times when two prior authorizations may be needed for one condition. For example, testing to diagnose a condition may require one prior authorization, while the rental/purchase of durable medical equipment to treat the diagnosed condition will require another prior authorization.
4. Provider contracts are regularly negotiated and there is no way to guarantee or predict continued provider participation in any given network. Providers are subject to change without notice to members. Please make sure to check carrier websites for the most up-to-date information regarding provider availability for your network.

GLOSSARY OF HEALTH COVERAGE & MEDICAL TERMS

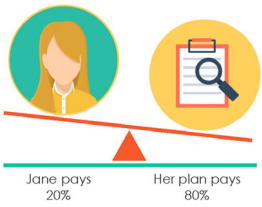
This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. In either case, the policy or plan governs. The full six-page glossary can be found on the WCIF website, WCIF.net/employees/2022-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**)

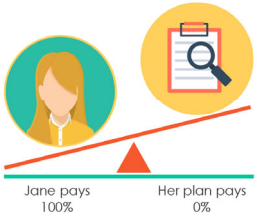
Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you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

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.



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.

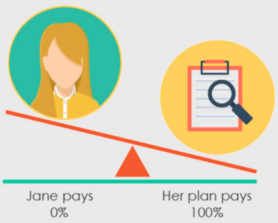
Deductible
The amount you ***could*** owe during a coverage period (usually one year) for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your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



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.

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

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.

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".

DENTAL / DELTA DENTAL OF WA

deltadentalwa.com | **1.800.554.1907** (customer service)

PLAN D

Delta Dental PPO℠ Enhanced Benefit Summary

Effective Date	January 1, 2022
Benefit Period	January 1, 2022 – December 31, 2022
Benefit Period Deductible	None
Benefit Period Maximum (Per Person) Class I Services do not apply toward benefit period maximum	$2,000
Orthodontia – Adults & Children Lifetime Maximum (Per Person)	50% $2,000

	Dental Network		
	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
Class I – Diagnostic & Preventive do not apply toward benefit period maximum			
Exams Cleaning (2x per benefit period) Fluoride (2x per benefit period) X-Rays Sealants **(on permanent teeth are covered up to age 15)**	**100%**	100%	100%
Class II – Restorative			
Fillings (including Composite Fillings) Endodontics (Root Canal) Periodontics Oral Surgery General Anesthesia/IV Sedation	**90%**	80%	80%
Class III – Major			
Dentures Partial Dentures Implants Bridges Crowns & Onlays	**50%**	50%	50%

This is a summary of benefits for comparison and isn't a contract. Once you're enrolled, you can get a benefits booklet that will provide all the details of your dental plan. Please feel free to call our customer service department or visit our website at **DeltaDentalWA.com** if you have any questions.

Keep in mind, you will likely experience the greatest savings when you see a Delta Dental PPO dentist.

Delta sends you an ID when first enrolled in the dental plan. If your card is not received or is lost, you are able to print a card from your personalized account on the Delta website—**DELTADENTALWA.com**

DENTAL / WILLAMETTE DENTAL

willamettedental.com | **1.855.433.6825** (customer service)

HIGH PLAN

SUMMARY OF BENEFITS

Washington Counties Insurance Fund-High Plan – WA204 – 1/1/2022

Willamette Dental Group

COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visit	$10 per Visit
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	Covered with the Office Visit Copay**
PROSTHODONTICS	
Complete Upper or Lower Denture	Covered with the Office Visit Copay**
Bridge (per Tooth)	Covered with the Office Visit Copay**
ENDODONTICS & PERIODONTICS	
Root Canal Therapy - Anterior	Covered with the Office Visit Copay
Root Canal Therapy - Bicuspid	Covered with the Office Visit Copay
Root Canal Therapy - Molar	Covered with the Office Visit Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	Covered with the Office Visit Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	$150***
Comprehensive Orthodontia Treatment	$1,800
DENTAL IMPLANTS	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	$20
Specialty Office Visit	$30 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Benefits for TMJ, implant surgery, and orthognathic surgery have a benefit maximum, if covered. **Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit. ***Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental of Washington, Inc.
Presented are just some of the most common procedures covered in your plan. The certificate of coverage contains a complete description of covered benefits and copays.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
028-WA(7/20)a

Please note—Willamette Dental does not issue ID cards. To make an appointment simply call customer service (see above) and provide them with your name and social security number.

VISION / VSP

VSP.com | 1.800.877.7195 (customer service)

EXTENDED PLAN

VSP Provider Network:
VSP Choice

TruHearing® Hearing Aid Discount Program

Offered in partnership with VSP Vision Care

TruHearing Customer Service:
1.877.396.7194

TRUHEARING.com

Using your VSP benefit is easy.

- Create an account at vsp.com. Once your plan is effective, review your benefit information.
- It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premium Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.
- At your appointment, tell them you have VSP. **There's no ID card necessary**. If you'd like a card as a reference, you can print one on VSP.com

Your Coverage with Out-of-Network Providers
Visit **VSP.com** for details, if you plan to see a provider other than a VSP network provider
Exam.....up to $45 Frame.....up to $70 Single Vision Lenses.....up to $30 Lined Bifocal Lenses.....up to $50 Lined Trifocal Lenses.....up to $65 Progressive Lenses.....up to $50 Contacts .....up to $105 Lens Options.....up to $5
Coverage with a participating retail chain may be different. Once your benefit is effective, visit VSP.com for details.

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$0
Prescription Glasses		**$15**
Frame	• $175 allowance for a wide selection of frames/$95 allowance at Costco®/Walmart/Sam's Club® • $195 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Anti-reflective coating • Scratch-resistant coating • UV Protection • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $0 $0 $0 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $155 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Diabetic Eyecare Plus Program	• Retinal screening for eligible members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Limitations and coordination with medical coverage may apply.	$0 $20 per exam
Additional Pairs of Eyewear		**$20**
Frame	• $175 allowance for a wide selection of frames/$95 allowance at Costco®/Walmart/Sam's Club® • $195 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Included in Prescription Glasses
Contacts (instead of glasses)	• $155 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to VSP.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

EAP / FIRST CHOICE HEALTH

firstchoiceEAP.com | 1.800.777.4114 (customer service) | eap@fchn.com (email)

Employee Assistance Program (EAP)

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, work/life, relationship, emotional, behavioral, mental health, and substance abuse concerns:

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

24/7 Online Access to EAP Services

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

FIRSTCHOICEEAP.com

In the box under the "Website Login" heading, enter username (all lower case):

wcif

24/7 TELEHEALTH

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

HERE'S HOW IT WORKS:

1. **Call FCH EAP at (800) 777-4114 or go online to FIRSTCHOICEEAP.com to request services.**
2. **FCH EAP provides your unique registration access to the BetterHelp platform.**
3. **Complete a brief matching questionnaire.**
4. **Match with a counselor and get started (may take up to 24 hours to receive match).**

NOTE: Crisis situations are not a good fit for this platform. Call (800) 777-4114 for immediate assistance.

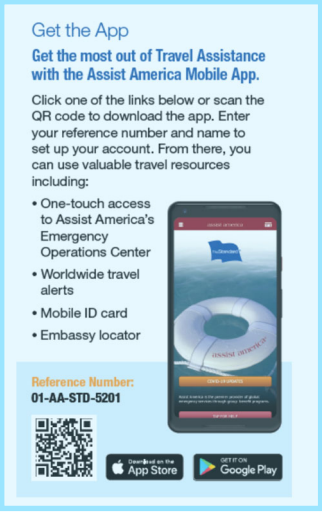
(800) 777-4114

LIFE/AD&D / THE STANDARD

STANDARD.com | **1.800.848.5132** (customer service)

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 provides you with a Basic Life/AD&D Plan that provides a $12,000 benefit. In addition, your employer also provides a $1,000 Dependent Life 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.



VTL / THE STANDARD

STANDARD.com | 1.800.848.5132 (customer service)

Voluntary Term Life (VTL)

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you suddenly pass away?

Guarantee issue coverage only applies during the initial eligibility period

Would your family have the funds to pay bills, your home mortgage, burial and funeral expenses? Would your family be able to live on one income and maintain their current lifestyle? What about medical expenses associated with a terminal illness? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Term Life (VTL) coverage.

How much coverage may I get for myself and my dependents?

- You may elect VTL coverage for yourself in units of $10,000 to a maximum of $500,000 or 6 times your annual salary (whichever is less) when combined with your employer-provided Basic Life/AD&D coverage.
- You may elect VTL coverage for your spouse in units of $10,000 to a maximum of $250,000, but not to exceed 100% of your VTL coverage.
- You may elect VTL coverage for your children in units of $2,000 to a maximum of $10,000, but not to exceed 100% of your VTL coverage.

*If you enroll within 31 days of benefit eligibility and meet the active work requirement, you will automatically qualify for up to a set amount of insurance coverage called the "guarantee issue amount".

Guarantee Issue Amount*	Employee……..$150,000 Spouse……..$30,000 Children……..$10,000
Age Reduction Schedule	At Age: 70……..65% of original amount 75……..45% of original amount 80……..30% of original amount Spouse coverage amount terminates the date your spouse reaches age 70.
Waiver of Premium	If you become totally disabled while insured under the voluntary life plan, are under age 60 and complete a waiting period of 180 days, your voluntary life insurance may continue without premium payment until age 65 provided you give Standard satisfactory proof that you remain totally disabled.
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your voluntary life maximum benefit to an overall maximum of $500,000 (basic life included).
Portability and Conversion	You may continue your insurance if your employment with your employer terminates. Please see the Portability and Conversion page of this Guide for eligibility and timeline requirements.

Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Age as of December 31	Premium per $10,000 of coverage		Age as of December 31	Premium per $10,000 of coverage	
	Employee	Spouse		Employee	Spouse
Under 20	$0.56	$0.60	45 — 49	$2.35	$2.45
20 — 24	$0.66	$0.70	50 — 54	$3.91	$4.09
25 — 29	$0.71	$0.75	55 — 59	$5.81	$5.87
30 — 34	$0.82	$0.90	60 — 64	$8.74	$9.57
35 — 39	$0.98	$1.05	65 — 69	$12.53	$13.53
40 — 44	$1.45	$1.55	70 or Over	$12.53	N/A

VAD&D / THE STANDARD

STANDARD.com | **1.800.848.5132** (customer service)

Voluntary Accidental Death & Dismemberment (VAD&D)

It's a fact of life. Accidents happen, often when you least expect them. Car wreck on the freeway, fall from a ladder at home, mishap with machinery. According to the Centers for Disease Control and Prevention accidents were the 3rd leading cause of death in 2017. What if it happened to you?

Would your family have the funds to pay bills, the home mortgage, burial and funeral expenses? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Accidental Death and Dismemberment (VAD&D) coverage. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Coverage Amount	Employee……..$25,000 increments to $500,000; Amounts over $250,000 limited to 10x your earnings Spouse……50% or 100% of your AD&D coverage amount Children……..10% of your AD&D coverage amount to a max of $30,000
Age Reduction Schedule	At Age: 70……..65% of original amount 75……..45% of original amount 80……..30% of original amount 85……..20% of original amount 90……..15% of original amount 95……..10% of original amount
Benefit Schedule	Table of Losses *Loss:* — *Percentage Payable* Loss of Life — 100% One hand or one foot — 50% Sight in one eye, speech, or hearing in both ears — 50% Two of more of the losses listed above — 100% Thumb and index finger of the same hand — 25% Quadriplegia — 100% Hemiplegia — 50% Paraplegia — 50%
Additional Features	Seat Belt Benefit Higher Education Benefit Career Adjustment Benefit Paralysis Benefit Common Disaster Benefit

Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Rate per unit (unit = $1,000)	
Employee	**$0.025**
Spouse/Domestic Partner	**$0.025**
Child(ren)	**$0.030**

LTD/ THE STANDARD

STANDARD.com | **1.800.848.5132** (customer service)

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.

Base Plan provided to eligible employees
Buy-Up Plan available to employees in Base Plan

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

Voluntary Buy-up Long Term Disability (Buy-up LTD)

Since every employee's needs are different, your employer also provides eligible employees with the opportunity to apply for coverage under a voluntary Buy-up LTD plan from The Standard. The advantages of the Voluntary Buy-up LTD coverage include choice, flexibility, convenience, and peace of mind.

If you are enrolled in the Base LTD plan, your employer offers you an opportunity to purchase Voluntary Buy-up LTD benefits on a discounted basis based on your salary. This is an excellent opportunity to help protect yourself and your lifestyle. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments. The coverage under the Voluntary Buy-up LTD plan increase the Base LTD plan benefits.

Benefit Amount: 60% of pre-disability earnings (up to $10,000 monthly salary)

Maximum Benefit: $6,000 per month

Waiting Period: 90 days from the date of disability

Guarantee issue coverage only applies during the initial eligibility period.

VSTD / THE STANDARD

STANDARD.com | **1.800.848.5132** (customer service)

Voluntary Short Term Disability (VSTD)

Can you go a month without a paycheck? How about three months? Or six months? The risk of disability is greater than you think. Recent statistics show that every 90 seconds someone files for bankruptcy in the wake of serious illness. Also, almost 3 in 10 of today's 20-year-olds will become disabled before reaching age 67. If you depend on your regular paycheck to pay your bills, what would happen if you became sick and couldn't work?

Voluntary Short Term Disability (VSTD) insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you meet your financial commitments when you need it most.

Guarantee issue coverage only applies during the initial eligibility period.

Benefit Waiting Period	30 Days
Benefit Percentage	60% of weekly earnings
Maximum Pre-disability Earnings	$1,667
Benefit Minimum	$15
Benefit Maximum	$1,000
Definition of Disability	You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of your own occupation or suffer at least a 20% earnings loss of indexed pre-disability earnings
Maximum Benefit Period	Option 1: 90 Days Option 2: 180 Days

Your employer offers you an opportunity to purchase VSTD benefits on a discounted basis based on your salary. This is an excellent opportunity to help protect yourself and your lifestyle. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Monthly Salary Range	Monthly Premium Due		Monthly Salary Range	Monthly Premium Due	
	180-Day Coverage	90-Day Coverage		180-Day Coverage	90-Day Coverage
	coincides with Base LTD enrollment	*coincides with Buy-Up LTD enrollment*		*coincides with Base LTD enrollment*	*coincides with Buy-Up LTD enrollment*
$999 or under	$0.95	$0.80	$4,000 — $4,499	$2.25	$1.55
$1,000 — $1,499	$1.10	$0.90	$4,500 — $4,999	$2.40	$1.65
$1,500 — $1,999	$1.35	$1.00	$5,000 — $5,499	$2.60	$1.75
$2,000 — $2,499	$1.50	$1.15	$5,500 — $5,999	$2.70	$1.90
$2,500 — $2,999	$1.75	$1.25	$6,000 — $6,499	$2.95	$1.95
$3,000 — $3,499	$1.85	$1.35	$6,500 — $6,999	$3.10	$2.10
$3,500 — $3,999	$2.10	$1.45	$7,500 or Over	$3.35	$2.20

PORTABILITY & CONVERSION / THE STANDARD

STANDARD.com | 1.800.848.5132 (customer service)

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
Voluntary Term Life	Yes	Yes
Long Term Disability (base)	No	Yes
Long Term Disability (buy-up)	No	Yes
Voluntary AD&D	No	No
Short Term Disability	No	No

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 or Conversion, please work with your employer to complete the employer statement on the forms, which are also available at WCIF.net

WORKSITE PLANS / METLIFE

METLIFE.com | 1.800.438.6388 (customer service)

WCIF has partnered with Metropolitan Life Insurance Company (MetLife) to provide employees with three types of voluntary insurance products — Accident, Hospital Indemnity, and Critical Illness. These products are priced on a group basis and the policies are guarantee issue[1] which means that no medical underwriting is required in order to obtain the benefit. Premiums are conveniently paid through your employer via payroll deduction on an after-tax basis.

Guarantee issue coverage is always available

ACCIDENT INSURANCE

Accidents can happen when you least expect them. And while you can't always prevent them, you can get help to make your recovery less expensive and stressful. In the U.S. there are approximately 40 million trips to the emergency room annually due to injuries.[2] These visits can be expensive—in fact, ER bills average around $1,233 a visit,[3] and even seemingly small injuries can come with unexpected high hospital bills.

Accident Insurance works to complement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that provides a financial cushion for life's unexpected events by providing you with a lump-sum payment (one convenient payment all at once) when your family needs it most. The payment you receive is yours to spend however you like. It pays if you have tests, receive medical services, treatment, or care for one of more that 150 covered events as defined in your group certificate. This includes hospitalization resulting from an accident, and accidental death & dismemberment[4].

HOSPITAL INDEMNITY INSURANCE

Few people budget for hospital bills. No one ever expects to be in the hospital. And your stay can require a variety of treatments, testing, therapies and other services—- each of which can mean extra out-of-pocket costs, beyond what your medical plan may cover.

Hospital Indemnity Insurance works to complement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that can help safeguard your finances for life's unexpected events by providing you with a lump-sum payment (one convenient payment all at once) when your family needs it most. The payment you receive is yours to spend however you like. It typically pays, as long as the policy and certificate requirements are met, a flat amount upon your hospital admission and a daily amount paid from each day of your stay (confined to the hospital).[4] It also provides payment if you are admitted to or have to stay in an Intensive Care Unit (ICU), as well as other added benefits and services too.[5]

CRITICAL ILLNESS INSURANCE

Your family's expenses will continue if and when a critical illness occurs. Studies show that some families spend as much as $14,444 or more during a time of critical illness and recovery.[6] And while financial experts recommend having 3—9 months of living expenses set aside to help in an emergency situation[7] like undergoing a serious illness, with today's economy most families don't have that kind of money in reserve.

Critical Illness Insurance is coverage that can help cover the extra expenses associated with a serious illness. When a serious illness happens to you or a loved one, this coverage provides you with a lump sum payment of Initial Benefits upon diagnosis. The Total Benefit Amount available to you is three (3) times the Initial Benefit Amount in the event that you suffer more than one Covered Condition. Payment(s) you receive will be made in addition to any other insurance you have and may be spent as you see fit.

[1] Coverage is guaranteed provided: (1) the employee is actively at work, and (2) dependents to be coverage are not subject to medical restrictions as set forth on the enrollment form and in the Certificate.. Some states require the insured to have medical coverage. Additional restrictions apply to dependents servicing in the armed forces or living overseas.

[2] Centers for Disease Control and Prevention: Emergency Department Visits. CDC/National Center for Health Statistics Accessed March 2018

[3] "Outrageous E.R. Hospital Charges: What to Do", FoxBusiness.com. June 27, 2013

[4] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

[5] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See MetLife's Disclosure Statement or Outline of Coverage/ Disclosure Document for full details.

[6] MetLife Accident and Critical Illness impact study, October 2013

[7] www.bankrate.com, How big should your emergency fund be:, Accessed January 2018

ACCIDENT / METLIFE

METLIFE.com | **1.800.438.6388** (customer service)

Plan Highlights

Covered Conditions	Low Plan MetLife Accident Insurance Pays You	High Plan MetLife Accident Insurance Pays You
Injuries – *12 covered injury types*	Ranging from **$25 – $5,000** per injury	Ranging from **$50 – $10,000** per injury
Medical Services & Treatment – *15 covered medical services & treatments*	Ranging from **$15 – $1,000** per medical service/treatment	Ranging from **$25 – $2,000** per medical service/treatment
Hospital Coverage[1] (due to an Accident)	Admission – **$500** per accident ICU Supplemental Admission – **$500** per accident Confinement – **$100** a day, up to **31** days ICU Supplemental Confinement – **$100** a day,	Admission – **$1,000** per accident ICU Supplemental Admission – **$1,000** per accident Confinement – **$200** a day, up to 31 days ICU Supplemental Confinement – **$200** a day,
Accidental Death	**$25,000** **$75,000** if passenger on common carrier[2]	**$50,000** $150,000 if passenger on common carrier[2]
Dismemberment, Loss & Paralysis	**$250 – $10,000** per injury	**$500 – $50,000** per injury
Additional Benefits – Lodging [3]	**$100** per night, up to 30 nights	**$200** per night, up to 30 nights

[1] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities.
[2] Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/ Disclosure Documents for specific details. Be sure to review other information contained in the worksite products booklet for more details about plan benefits, monthly rates and other terms and conditions."
[3] The lodging benefit is not available in all states. It provided a benefits for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from the insured's primary residence.

Plan Rates

Accident Insurance	**Monthly Cost to You**	
Coverage Options	Low Plan	High Plan
Employee	$8.65	$16.48
Employee & Spouse	$16.89	$32.13
Employee & Child(ren)	$19.52	$37.10
Employee & Spouse/Child(ren)	$23.44	$44.57

For detailed plan design information, benefit examples, and frequently asked questions, please refer to the Group Worksite Products booklet or the appropriate certificate, which contains the detailed information needed.

HOSPITAL INDEMNITY / METLIFE

METLIFE.com | **1.800.438.6388** (customer service)

Plan Highlights



Covered Conditions[1]	Low Plan MetLife Hospital Indemnity Pays You	High Plan MetLife Hospital Indemnity Pays You
Hospital Coverage (Accident and Sickness)		
Admission	Admission – **$500** 1 time per calendar year ICU Supplemental Admission – **$500** 1 time per calendar year	Admission – **$1,000** 1 time per calendar year ICU Supplemental Admission – **$1,000** 1 time per calendar year
Confinement	Confinement – **$100** a day, up to 15 days[2] ICU Supplemental Confinement – **$100** a day, up to 15 days	Confinement – **$200** a day, up to 15 days[2] ICU Supplemental Confinement – **$200** a day, up to 15 days
Inpatient Rehab	**$100** per day, up to 15 days per calendar year	**$200** per day, up to 15 days per calendar year

[1] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate..
[2] When plan includes an Admission benefit, Confinement begins on day 2.

Plan Rates

Hospital Indemnity Insurance	Monthly Cost to You	
Coverage Options	Low Plan	High Plan
Employee	$10.59	$20.89
Employee & Spouse	$21.75	$42.92
Employee & Child(ren)	$17.85	$35.23
Employee & Spouse/Child(ren)	$29.01	$57.25

For detailed plan design information, benefit examples, and frequently asked questions, please refer to the Group Worksite Products booklet or the appropriate certificate, which contains the detailed information needed.

CRITICAL ILLNESS

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Covered Conditions

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer[1]	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer[1]	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not Applicable
Alzheimer's Disease[2]	100% of Initial Benefit	Not Applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not Applicable
22 Listed Conditions	25% of Initial Benefit	Not Applicable

22 Listed Conditions

MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one payment for each Listed Condition in his/her lifetime. The Listed Conditions are: Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

[1] Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount.

[2] Please review the Outline of Coverage for specific information about Alzheimer's Disease.

Initial Benefit Amount

You have a **choice** of a $15,000 or $30,000 Initial Benefit Amount	Your Total Benefit Amount will be **3 times** the Initial Benefit Amount you selected	You can receive **Initial and Recurrence Benefit**[1] payments until your Total Benefit Amount is reached

Example of Initial & Recurrence Benefit Payments[2]

The example below illustrates an employee who elected an Initial Benefit of $30,000 and has a Total Benefit Amount of 3 times (or 300%) of the Initial Benefit Amount or $90,000

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of $30,000 or 100%.	$60,000
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of $15,000 or 50%	$45,000
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of $30,000 or 100%	$15,000

[1] Your plan pays a Recurrence Benefit equal to the Initial Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences. We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.

[2] This example is for illustrative purposes only. The MetLife Critical Illness Insurance Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

For detailed plan design information, benefit examples, and frequently asked questions, please refer to the Group Worksite Products booklet or the appropriate certificate, which contains the detailed information needed.

CRITICAL ILLNESS

METLIFE.com | 1.800.438.6388 (customer service)

Health Screening Benefit

MetLife provides an annual Health Screening Benefit for taking one of the eligible screening/prevention measures. This coverage would be in addition to the Total Benefit Amount payable for previously mentioned Covered Conditions.

MetLife will provide an annual benefit of $50 per calendar year and will only pay one health screening benefit per covered person per calendar year.

Eligible screening/prevention measures* may include:

• Annual physical exam	• Blood test for total cholesterol	• Colonoscopy
• Fasting blood glucose	• Lipid panel	• Mammogram
• PAP smears	• PSA test	• Serum cholesterol

*Please refer to the Group Worksite Products booklet for the full list of screening/prevention measures.

Preexisting Condition Limitation/Exclusion

The MetLife Critical Illness plans contain a preexisting condition limitation.

A preexisting condition is defined as a sickness or injury for which, in the three (3) months before a covered person becomes insured under a certificate, or before any Benefit Increase with respect to such covered person:

- Medical advice, treatment or care was sought by such covered person, or recommended by, prescribed by, or received from a physician or other practitioner of the healing arts; or
- Symptoms, or any medical or physical conditions existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

MetLife will not pay benefits for a covered condition that is caused by, or results from a preexisting condition if the covered condition first occurs during the first six (6) months that a covered person is insured under the certificate.

With respect to a Benefit Increase, MetLife will not pay benefits for such Benefit Increase for a covered condition that is caused by or results from a preexisting condition if the covered condition occurs during the first six (6) months after such an in the Total Benefit Amount.

This provision does not apply to benefits for the following covered conditions: Heart Attack and Stroke.

Plan Rates

The rates outlined below are the **monthly premium for $1,000 of coverage** for the critical illness plans. For the Low plan, locate the appropriate rate below and times by 15. For the High plan, locate the appropriate rate below and times by 30.

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse/Children
<25	$0.17	$0.30	$0.35	$0.48
25-29	$0.19	$0.32	$0.36	$0.49
30-34	$0.26	$0.43	$0.44	$0.61
35-39	$0.38	$0.61	$0.56	$0.79
40-44	$0.58	$0.92	$0.76	$1.09
45-49	$0.86	$1.33	$1.04	$1.51
50-54	$1.25	$1.91	$1.42	$2.08
55-59	$1.77	$2.69	$1.94	$2.86
60-64	$2.56	$3.88	$2.73	$4.05
65-69	$3.89	$5.87	$4.06	$6.05
70+	$5.89	$8.87	$6.06	$9.04

For detailed plan design information, benefit examples, and frequently asked questions, please refer to the Group Worksite Products booklet or the appropriate certificate, which contains the detailed information needed.

WORKSITE PLANS / METLIFE

METLIFE.com | **1.800.438.6388 (customer service)**

MyBenefits Portal / METLIFE.com/mybenefits

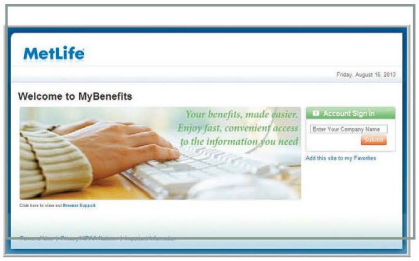
MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information. MetLife is able to deliver services that allows you to manage your benefits.

The MyBenefits Portal may also be used to submit claims online once you are registered and your account is active.

Registration Process for MyBenefits

Provide Your Group Name

Access MyBenefits at www.metlife.com/mybenefits and enter your group name Washington County Insurance Fund (or WCIF) and click **'Submit.'**

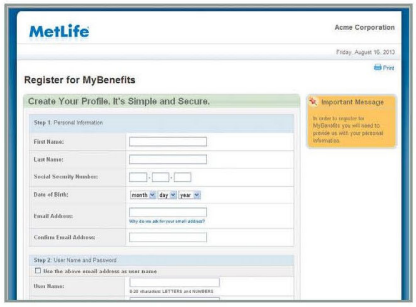


The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Register Now'** and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.



Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

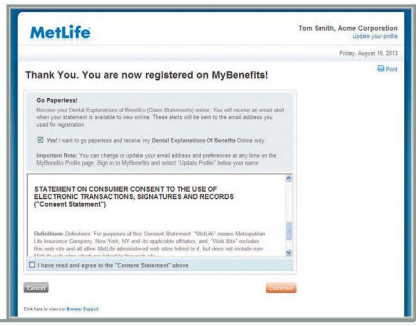
Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the email address you provided during registration.



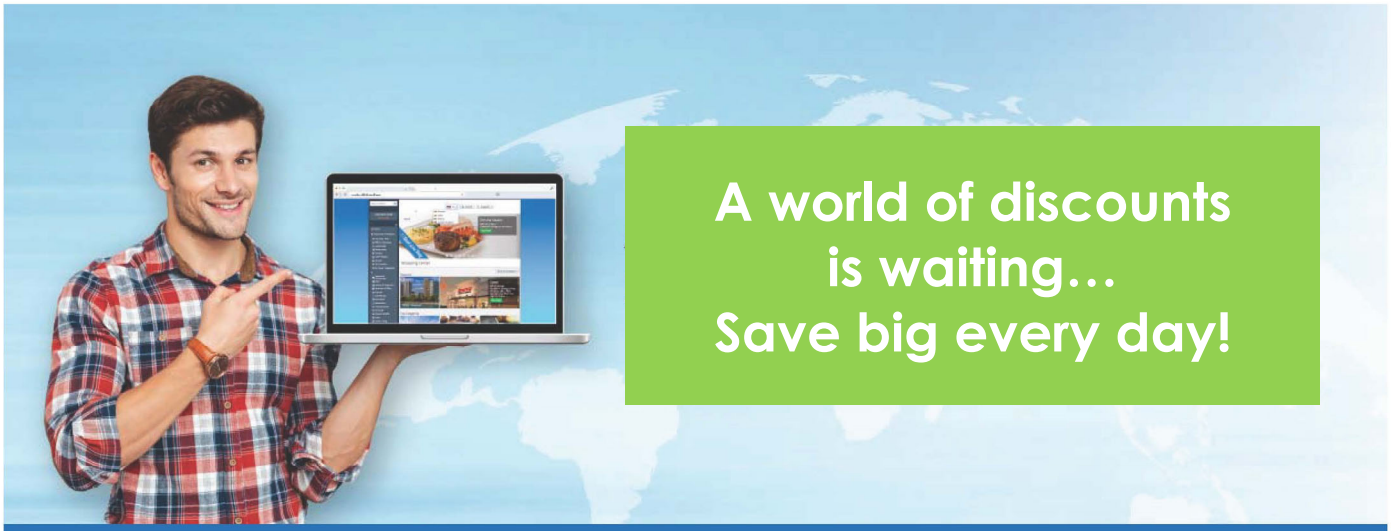
Continuation of Insurance Provision

When you leave employment or wish to cancel your MetLife accident, hospital indemnity or critical illness insurance coverage, you have been continuously covered under a MetLife plan for six (6) months prior to your termination date and you are under age 75, you are eligible for continuation of coverage. MetLife will send you a letter reminding you of the Continuation of Insurance provision under your policy which allows you to continue coverage by paying premiums directly to MetLife. The policy/policies will be cancelled if you take no action when you receive the letter.

If you wish to elect Continuation of Insurance, you will need to complete and return the form provided in the mailed packet or contact MetLife at 1-800-GET-MET8 (1-800-438-6388) Monday through Friday. **MetLife must receive your completed Election of Continuation Insurance Form or you must call MetLife no later than 31 days from the date of termination. If you do not call or if MetLife does not receive the election form by the deadline, your coverage will be terminated.**

For detailed plan design information, benefit examples, and frequently asked questions, please refer to the Group Worksite Products booklet or the Certificate, which contains the detailed information needed.

BenefitHub Discount Center



Welcome to WCIF Discounts & Rewards!

Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports & Outdoors

Hertz · CityPASS · SixFlags · amc THEATRES · Hotels · GROUPON · Budget · DELL · employee AUTO BUYING powered by TRUECar · Vitamix · Sam's Club · Nutrisystem · Office DEPOT OfficeMax · Lenovo · AVIS · TICKETMONSTER · hp · jiffy lube

It's easy to access and start saving!

1. Go to: wcif.benefithub.com
2. Referral Code: **IBWY7X**
3. Complete Registration

Questions? Call 1-866-664-4621 or email customercare@benefithub.com

How to Find a Provider

You can search for an in-network provider online by following the steps outlined below.

Premera Blue Cross—Medical

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”.
5. A list of providers will appear along with contact information.

If you have not already done so, it is a good idea to create a secure on-line member account with Premera in order to access tools designed to help you manage your medical benefits.

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.

How to Find a Provider

You can search for an in-network provider online by following the steps outlined below.

Delta Dental of Washington —Dental

1. Go to https://www.deltadentalwa.com
2. Hover over “ONLINE TOOLS” at the top of the screen, then “FIND A DENTIST”.
3. Fill in as much information as possible to narrow the search with the network.
    A. Indicate the mile range of your search (i.w. within 5 miles)
    B. Be sure to select the correct network : Delta Dental PPO
4. Click “SEARCH”.
5. A list of providers will appear along with contact information.

If you have not already done so, it is a good idea to create a secure on-line member account with Detla in order to access tools designed to help you manage your dental benefits.

Willamette Dental—Dental

1. Go to https://www.willamettedental.com
2. Click “LOCATIONS” at the top of the screen.
3. Fill in your City, State or Zip Code.
4. A list of Office Locations will appear. Select the Office your are interested in.
5. A list of providers will appear along with Office contact information.

VSP Vision Care —Vision

1. Go to https://www.vsp.com
2. Click “FIND A DOCTOR” at the top left of the screen.
3. Click “ADVANCED SEARCH” in middle right of screen to choose network— Choice
4. Fill in your Zip Code or Street Address, City, State.
5. A list of Office Locations will appear. Select the Office your are interested in.
6. A list of providers will appear along with Office contact information.

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 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 your 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
- 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 peopled 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, 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).

Plan Year	2022 Calendar Year
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 lymphedemas

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. 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

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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 2022 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1, 2021, through January 15, 2022. From December 15, 2021 to January 15, 2022, coverage will be effective February 1,2022. After January 15, 2022, you can get coverage through the Marketplace for 2022 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 9.61 percent of your household income for the year, 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 or 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.

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 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, 2021, 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
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.CMS.HHS.gov
1.877.267.2323, Menu Option 4, Ext. 61565

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*

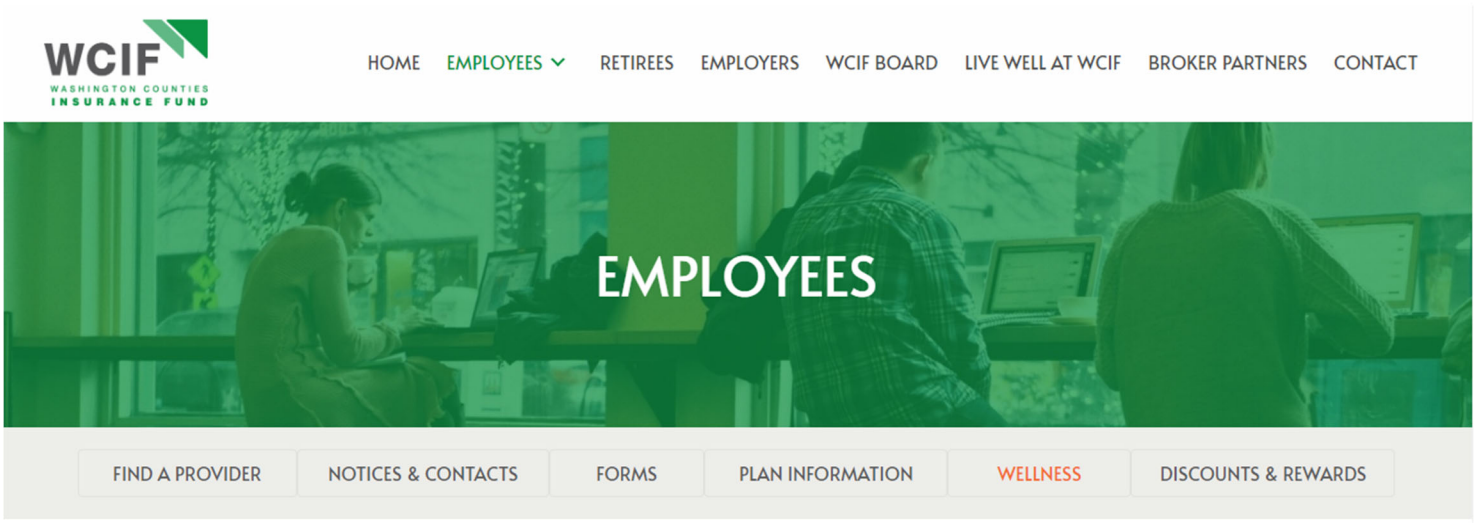
Newborns' and Mothers' Health Protection Act of 1996

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.

WCIF.net /employees



FIND A PROVIDER

Links to carrier websites for carrier-specific online provider directories.

FORMS

Enrollment forms, plan forms, and materials for administrators.

PLAN CONTACTS

General Customer Service numbers.

NOTICES

Required health care notices and carrier privacy notice links.

PLAN INFORMATION

Summaries, SBCs, Summary Plan Documents, and other plan information by carrier.

WELLNESS

Live Well at WCIF Wellness Program portal.

WCIF DISCOUNTS AND REWARDS

Connect to BenefitHub for access to discounts on travel, entertainment & more!
Access code: IBWY7X

QUESTIONS?

Contact your Human Resource Department or visit WCIF.net

800.344.8570 (toll free)

info@wcif.net

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