



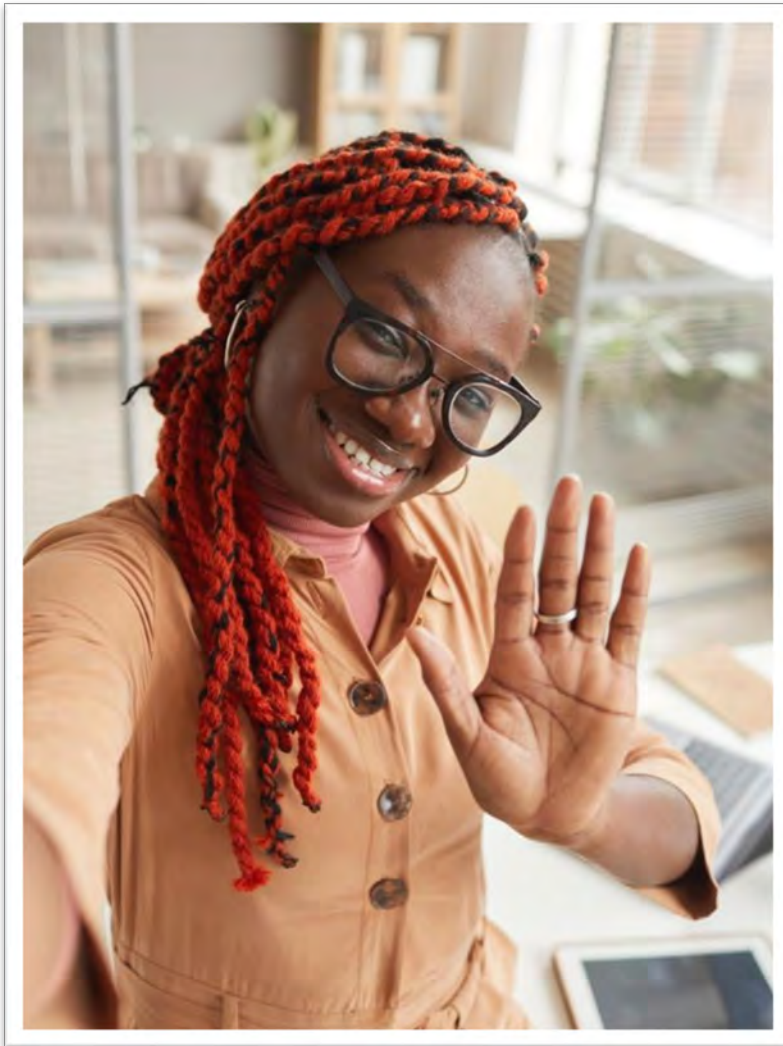
2025–2026

Employee Benefits Guide

Provided to you by:



Welcome



We would like to welcome you to the 2025-2026 annual benefits summary package for **NAVIA BENEFIT SOLUTIONS**. This packet contains summaries of the benefits offered to you by **NAVIA BENEFIT SOLUTIONS**. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This benefit guide provides an overview of benefit plans, including eligibility, election periods and costs. In addition, the guide offers descriptions and explanations of each coverage plan option. We urge you to carefully consider all aspects of these programs, including their premiums, accessibility to health care services, flexibility and restrictions.

Info on the Go!

Scan with your Smartphone to access your 2025-2026 Benefits Guide and enrollment materials online **ANYTIME**.



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A Note About This Benefits Guide

Full details are available in the legal documents governing the individual plans. If there is any discrepancy or conflict between the plan documents and the information presented here, the plan documents govern. If you have any questions about the contents of this guide or how this information may apply to you, please contact your Human Resources Department.

Benefits Overview

Here's a quick look at the **NAVIA BENEFIT SOLUTIONS** benefits available to full-time employees. Additional details on all these benefits are included in this guide. If you have any questions about the benefits in this guide, feel free to call the benefit providers directly or visit their websites. See the table on page 24 for contact information. Our HR Team is also available to help answer any questions you may have. Please don't hesitate to call us at **(425) 452-3470**, or e-mail JTarasewicz@naviabenefits.com if you have any questions.

Benefit	Enrollment Optional or Automatic	Coverage
Medical	Optional You and NAVIA BENEFIT SOLUTIONS share the cost	NAVIA BENEFIT SOLUTIONS offers two different plans through Benefit Plan Administrators (BPA) including one High Deductible Health Plan (HDHP/HSA) and one Preferred Provider Organization Plan (PPO)
Health Savings Account (HSA)	Optional You contribute	If you elect to participate in a HDHP/HSA, you can contribute pre-tax dollars to use for eligible health care expenses.
Dental Reimbursement	Optional You and NAVIA BENEFIT SOLUTIONS share the cost	NAVIA BENEFIT SOLUTIONS offers a dental reimbursement program up to \$1,500 per member per plan year.
Vision Reimbursement	Optional You and NAVIA BENEFIT SOLUTIONS share the cost	NAVIA BENEFIT SOLUTIONS offers a vision reimbursement program up to \$650 per member per plan year.
Flexible Spending Accounts (FSA)	Optional You contribute	If you elect to participate in an FSA, you can contribute pre-tax dollars to use for eligible health care and dependent care expenses. You must open an account through NAVIA BENEFIT SOLUTIONS.
Basic Life and AD&D	Automatic NAVIA BENEFIT SOLUTIONS pays the cost	NAVIA BENEFIT SOLUTIONS pays for Basic Life and AD&D in the amount of two times your Basic Annual Earnings up to a maximum of \$200,000.
Voluntary Life and AD&D	Optional You pay the cost	You may elect life insurance in \$10,000 increments to a maximum of \$500,000. You can also purchase life insurance for your spouse and child(ren).
Voluntary Short-Term Disability (STD)	Optional You pay the cost	You may elect disability coverage in the amount of 60% of your annual base salary to a weekly maximum of \$1,500.
Long-Term Disability (LTD)	Automatic NAVIA BENEFIT SOLUTIONS pays the cost	You are eligible for coverage after 90 days of disability in the amount of 60% of annual base salary to a monthly maximum of \$10,000.
Commuter Benefits	Optional You pay the cost	You can put aside money on a pre-tax basis to pay for work-related commuting and parking expenses.

Eligibility and Enrolling

Who is Eligible?

If you are a full-time employee, you are eligible to enroll in the benefits described in this guide. You are eligible for benefits on the **first of the month following 60 days of employment**.

You may enroll your eligible dependents in the same plans you choose for yourself, including medical, dental, and vision coverage. Eligible dependents may include the following:

- ✓ Your legal spouse
- ✓ Your Domestic Partner (same or opposite sex) or common law spouse
- ✓ Your children up to age 26
- ✓ Your unmarried dependent children over age 26 who are incapable of self-care because of a disability and who rely on you for support

When you enroll dependents, please submit copies of the following (if applicable):

- ✓ Marriage Certificate, an Affidavit of Domestic Partnership or Common Law Marriage
- ✓ Adoption Papers or papers to show legal adoption proceedings have started
- ✓ Birth Certificate(s)

If you do not provide this documentation within 31 days of hire, your dependents will not be enrolled in benefits.

Enrolling For Coverage

Your enrollment period is an important time to review your benefits and choose the best options for you and your family. Review the 2025–26 Employee Benefits Guide to understand the coverage available and changes to the **NAVIA BENEFIT SOLUTIONS** Benefit Program. **You can enroll for coverage within 31 days of your hire date or during the annual open enrollment period.**

Newly hired full-time employees enrolling for the first time will make their benefit elections via **Namely**, our online enrollment tool. You can make your benefit elections during the enrollment window, and coverage begins on the first of the month following 60 days of employment.

Please visit <https://navia.namely.com/> to create your account profile. Your personal benefit elections will be housed in **Namely**.



Active Enrollment

For 2025-2026, **EVERYONE must access Namely to enroll or waive benefits**. You must complete the registration process on Namely and make your elections between **May 27th, 2025 to June 6th, 2025**, that will be effective as of July 1, 2025.

If you do not access Namely to make your benefit elections during open enrollment, you will NOT be enrolled, and your benefits coverage will end June 30, 2025. Please note, this is a change from previous years. Current elections will NOT remain in force for 2025-26, if you do nothing.

Once you access your benefit information, please be sure to verify personal information and enter any missing information related to your benefits, such as dependent and beneficiary information. If you have questions, please contact Human Resources.

Eligibility and Enrolling

Changing Your Coverage During the Year



Whether you are a newly hired employee or a current employee enrolling during the annual open enrollment, the elections you make at this time will remain in effect until **NAVIA BENEFIT SOLUTIONS** next open enrollment period, unless you have a qualifying life event (as defined by the IRS) that allows a mid-year plan change.

These changes include (but are not limited to):

- ✓ Birth or adoption of a baby or child
- ✓ Loss of other healthcare coverage
- ✓ Eligibility for new healthcare coverage
- ✓ Marriage
- ✓ Divorce
- ✓ Change in child's dependent status

If you experience a qualifying life event, or if you have questions, please contact Human Resources (HR). **You have 30 days after a qualifying event to notify HR and request a change to your benefit elections.**

NOTE: The benefit changes you make must be consistent with the life event.

When Dependent Children Age Out

Dependent children can remain on the medical, dental and/or vision coverage(s) until the end of the month in which they turn 26, at which time their coverage will be cancelled. For Life Insurance, the aging out rule will be the same, unless their birthday is on the first of the month, in which case coverage would end last day of prior month (day before 26th birthday).

READY

SET

ENROLL

Medical & Prescription Drug Benefits

Plan Year—July 1st through June 30th



NAVIA BENEFIT SOLUTIONS offers a comprehensive benefits program to help you and your family protect your health and financial security. Your benefits are a valuable part of your compensation; we encourage you to learn how your plans work so you can get the most from them. These plans encourage you to seek care from In-Network providers, which provide a higher level of benefit. You may choose to use Out-Of-Network providers, but if you do, your benefits will be reduced, and your out-of-pocket expense will increase. These plans do not require you to select a primary care provider, nor is it necessary to obtain a referral in order to see a specialist.

The following chart provides a brief summary of both Medical Plans In-Network benefit options. Complete benefit summaries, including Out-of-Network benefits, are available on the **Namely** Portal.

BENEFIT OPTIONS (IN-NETWORK)		BASE HRA PLAN	HSA PLAN	BUY UP PPO PLAN
Network Name		Cigna PPO	Cigna PPO	Cigna PPO
HSA Eligible		No	Yes	No
Calendar Year Deductible	Individual	\$2,000	\$1,650	\$500
	Family	\$6,000	\$3,300	\$1,500
		**Embedded	NON-Embedded *Aggregate*	**Embedded
Coinsurance		20%	20%	20%
Calendar Year Out-of-Pocket Maximum	Individual	\$6,000	\$6,000	\$4,000
	Family	\$12,000	\$12,000	\$8,000
Includes Deductible, Coinsurance, Copays		**Embedded	NON-Embedded *Aggregate*	**Embedded
Physician Office Visit	Primary	20% after deductible	20% after deductible	\$20 copay (deductible <u>does not</u> apply)
	Specialist	20% after deductible	20% after deductible	\$50 copay (deductible <u>does not</u> apply)
Preventive Care	Adult / Well Child	Covered at 100%	Covered at 100%	Covered at 100%
Telemedicine		20% after deductible	20% after deductible	\$20 copay (deductible <u>does not</u> apply)
Emergency Room		20% after deductible	20% after deductible	\$100 copay, deductible and coinsurance
Urgent Care		20% after deductible	20% after deductible	\$20 copay (deductible <u>does not</u> apply)
Inpatient Services		20% after deductible	20% after deductible	20% after deductible
Outpatient Services		20% after deductible	20% after deductible	20% after deductible
Outpatient Diagnosis	X-Ray, Laboratory, Complex Imaging	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs	Retail (30-day supply)	\$20/\$50/\$90/20% to \$250 max	20% after deductible	\$20/\$50/\$90/20% to \$250 max
	Mail Order (90-day supply)	\$50/\$125/\$225/20% to \$625 max	20% after deductible	\$50/\$125/\$225/20% to \$625 max

* **Aggregate** deductible and out-of-pocket (OOP), means once Family Deductible is met, all family members will be considered as having met their deductible for the remainder of the contract year. There is no Individual Deductible to satisfy within the Family Deductible.

** **Embedded** deductible and out-of-pocket (OOP), means that a "per member" deductible and OOP are embedded within the "per family" thresholds. Each covered family member is subject only to their "per member" deductible or OOP, and the family's exposure as a whole is limited by the family deductible and OOP limits.

Medical & Prescription Drug Benefits



Medical Key Reminders

- ✓ In order to limit your Out-of-Pocket expenses, please seek services from a **Cigna PPO** provider. To find a provider, visit <https://hcpdirectory.cigna.com/web/public/consumer/directory>.
- ✓ If services are provided by a non-**Cigna** provider, the member is responsible for any amounts that exceed the "allowable charges," in which case balance billing could occur.
- ✓ Dependent Child Age Limits: Covered to age 26.

Prescription Drug Coverage

We know prescription drug coverage is important to you and your family, so when you elect medical coverage, you are automatically covered under the prescription drug plan. You may fill your prescriptions at participating retail pharmacies. Under the PPO Plan, the mail order option allows you to buy qualified prescriptions in larger 90-day quantities for the same copay amount as a 90-day supply at the retail pharmacy. Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

There are several categories of drugs under the plans. The differences between these categories are described below:

- ✓ **Tier 1 - Generic:** Frequently prescribed generic drugs. (\$20 Copay)
- ✓ **Tier 2 - Preferred Brand:** Lowest cost brand name drugs. (\$50 Copay)
- ✓ **Tier 3 - Non-Preferred Brand:** Brand names drugs with higher costs than preferred brand name drugs. (\$90 Copay)
- ✓ **Specialty:** Typically for chronic high-cost conditions. Specialty drugs are limited to a 31-day supply and must be obtained through CVS/Caremark's Specialty Pharmacy (<http://www.cvscaremarkspecialtyrx.com>).

Choose Generics

The member pays the applicable copay only if the physician requires brand name Rx. If the member requests brand name when a generic is available, the member pays the applicable copay plus the difference between the two Rx. Be sure to discuss this with your physician when he or she writes your prescription.

Simply [register for an account](#) or sign into [your CVS Caremark account](#) to get individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies. You may also call CVS Caremark Customer Care at 1-800-552-8159.

Helpful Terms

Deductible—The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Coinsurance—The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 80%, you are responsible for paying the remaining 20% of the cost.

Copay—The fee you pay to a provider at the time of service.

Out-of-Pocket Maximum—The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Balance Billing—Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Where To Go For Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

Primary Care Center



When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?

- ✓ Routine checkups
- ✓ Preventive Services
- ✓ Immunizations
- ✓ Manage general care

What are the costs and time considerations?

- ✓ Often requires a copay and/or coinsurance.
- ✓ Normally requires an appointment.
- ✓ Usually little wait time with scheduled appointment.

Telemedicine



When would I use this?

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?

- ✓ Cold & flu symptoms
- ✓ Urinary tract infection
- ✓ Allergies
- ✓ Sinus problems
- ✓ Bronchitis

What are the costs and time considerations?

- ✓ Often requires a copay and/or coinsurance.
- ✓ Access to care is usually immediate. Some states may not allow for prescriptions through telemedicine or virtual visits.

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a **higher price** tag, so ask for clarification if the word emergency appears in the company name.

Urgent Care Center



When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for **non-life threatening** injuries or illnesses.

What type of care would they provide?*

- ✓ Strains, sprains
- ✓ Minor burns
- ✓ Minor broken bones
- ✓ X-rays
- ✓ Minor infections

What are the costs and time considerations?*

- ✓ Often requires a copay and/or coinsurance that is usually higher than an office visit.
- ✓ Walk-in patients welcome but waiting periods may be longer as patients with more urgent needs will be treated first.

Emergency Room



When would I use this?

You need immediate treatment for a serious **life threatening** condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*

- ✓ Heavy bleeding
- ✓ Spinal injuries
- ✓ Chest pain
- ✓ Severe head injury
- ✓ Major burns
- ✓ Broken bones

What are the costs and time considerations?*

- ✓ Often requires a much higher copay and/or coinsurance.
- ✓ Open 24/7 but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

* This is sample of services and may not be all-inclusive. ** Cost and time information represent average only and are not tied to a specific condition or treatment.

Dental and Vision Benefits

Dental Benefits

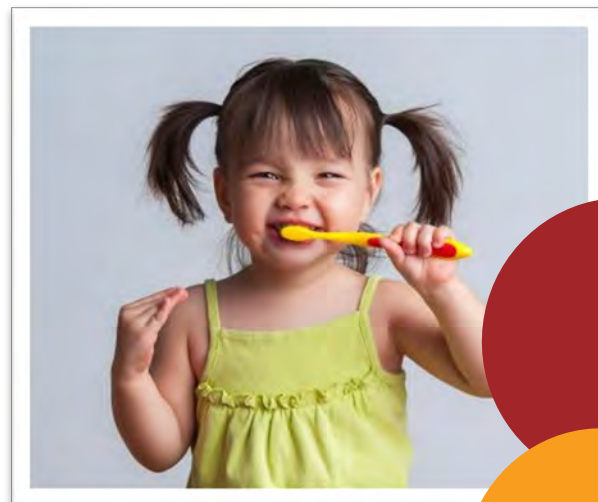
Plan Year—July 1st through June 30th

Regular visits to your dentist can do more than protect your smile; they can help protect your health as well. Recent studies have linked gum disease to damage elsewhere in the body, and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease. The company offers you a reimbursement dental plan through **NAVIA BENEFIT SOLUTIONS**.

The following chart shows the features of the **Dental** benefit option. For more information, contact Human Resources.

Benefit	Dental Reimbursement
First \$500	This first \$500 is reimbursed at 100%
Next \$600	The next \$600 is reimbursed at 80%
Next \$1,040	The next \$1,040 is reimbursed at 50%
Annual Plan Maximum Reimbursement*	\$1,500 per member

* Orthodontia is covered under this reimbursement plan



Vision Benefits

Plan Year—July 1st through June 30th

Your vision health is an important part of your complete wellness. Routine vision exams are important, not only for correcting vision, but because they can detect other serious health conditions. That's why **NAVIA BENEFIT SOLUTIONS** offers you a **reimbursement vision plan up to an annual maximum of \$650** per enrolled participant to be used for eligible vision expenses. Contact Human Resources for more information.



The information in this Enrollment Guide is presented for illustrative purposes, and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Cost of Coverage

Medical, Dental and Vision

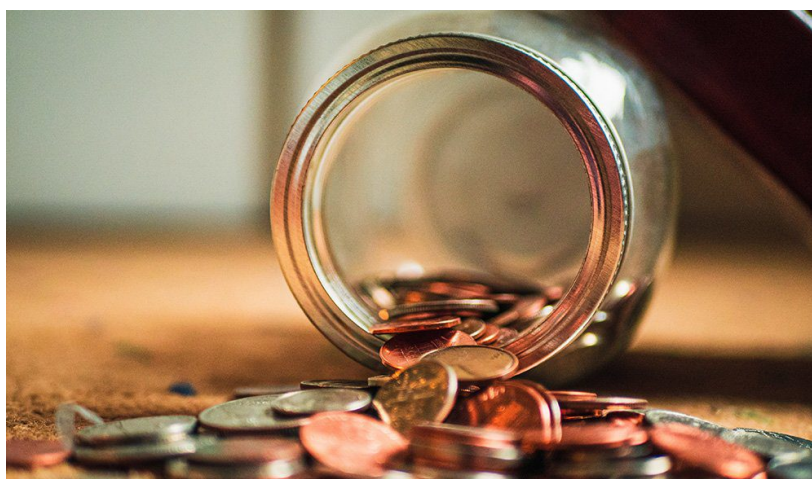
Per 26 Pay Periods



NAVIA BENEFIT SOLUTIONS pays a portion of your health care premiums; however, we do require employees contribute toward their health care costs as well. Employees pay a dollar amount based on the level of coverage they select. The following Employee Payroll Deductions will be effective for this plan year and will be reflected on your first paycheck after effective date.

MEDICAL PLAN Payroll Deductions with spousal surcharge (per 26 pay periods)			
TIER	BPA BASE HRA PLAN	BPA HSA PLAN	BPA BUY UP PPO PLAN
Employee	\$31.58	\$31.58	\$99.23
Employee+ Spouse	\$244.62	\$244.62	\$311.54
Employee +Child(ren)	\$48.46	\$48.46	\$178.15
Employee + Spouse + Child(ren)	\$281.54	\$281.54	\$394.62

DENTAL AND VISION PLAN Payroll Deductions (per 26 pay periods)			
Employee	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)
\$5.00	\$25.00	\$10.00	\$35.00



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Health Savings Account (HSA)

Plan Year—July 1st through June 30th



NAVIA BENEFIT SOLUTIONS will offer an HSA to those who enroll in the BPA HSA Medical Plan. The HSA provides you the ability to save and use pretax dollars to pay for eligible medical expenses (i.e., deductible). You can save approximately 25 percent of each dollar spent on medical expenses when you participate.

Contributions to your HSA are withdrawn from your paycheck on a pre-tax basis. This means you don't pay federal income tax, Social Security taxes, or local income taxes on the portion of your paycheck you contribute to the HSA. See "HSA Taxation" on page 11.

What are the benefits of an HSA?

- ✓ **Funds Rollover**—No "use it or lose it" provision.
- ✓ **Earns Interest**—Monies accrue tax-free interest.
- ✓ **Portable**—Yours to keep. If you leave your employer, your HSA funds go with you.

The IRS HSA Contribution Limits are as follows:

Annual Contribution Limits	2025	2026
Single	\$4,300	\$4,400
Family	\$8,550	\$8,750



NOTE: If you are age 55 or older, you may make an additional "catch-up" contribution of \$1,000.

NAVIA BENEFIT SOLUTIONS administers the HSA services. You will be able to manage your account online to submit eligible claims, review your account balance, review your claim history, and more. We will provide you more information about the Welcome Kit and how to set up your account.

****** Your contribution limits are calculated based coverage under the company's HDHP for the full calendar year, exclusive of any "catch-up contribution." Please contact HR to confirm your contribution limit if you have a mid-year enrollment change.

Health Savings Account (HSA)

IRS-Qualified Medical Expenses

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. Funds used to pay for IRS-qualified medical expenses are always tax-free. HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to Navia Benefits Solutions, you must save your bills and receipts for tax purposes.

Examples of IRS-Qualified Medical Expenses:

- | | | |
|--|------------------------|-----------------------------|
| ✓ Acupuncture | ✓ Eyeglasses | ✓ Pregnancy Test Kit |
| ✓ Ambulance | ✓ Eye Surgery | ✓ Prosthesis |
| ✓ Annual Physical Examination | ✓ Hearing Aids | ✓ Psychiatric Care |
| ✓ Bandages | ✓ Home Care | ✓ Special Education |
| ✓ Birth Control Pills, contraceptive devices | ✓ Hospital Services | ✓ Sterilization |
| ✓ Body Scan | ✓ Insurance Premiums | ✓ Stop-Smoking Programs |
| ✓ Breast Pumps and Supplies | ✓ Laboratory Fees | ✓ Surgery |
| ✓ Breast Reconstruction Surgery | ✓ Lactation Expenses | ✓ Transplants |
| ✓ Chiropractor | ✓ Learning Disability | ✓ Vasectomy |
| ✓ Contact Lenses | ✓ Long-Term Care | ✓ Vision Correction Surgery |
| ✓ Crutches | ✓ Medicines | ✓ Weight-Loss Program |
| ✓ Dental Treatment | ✓ Nursing Home | ✓ Wheelchair |
| ✓ Diagnostic Devices | ✓ Nursing Services | ✓ Wig |
| ✓ Disabled Dependent Care Expenses | ✓ Optometrist | ✓ X-Ray Fees |
| ✓ Eye Exam | ✓ Oxygen | |
| | ✓ Physical Examination | |

Ineligible Medical Expenses May Include:

- | | | |
|--|-------------------------------------|--|
| ✗ Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby | ✗ Future Medical Care | ✗ Medicines and Drugs From Other Countries |
| ✗ Controlled Substances | ✗ Hair Transplant | ✗ Nonprescription Drugs and Medicines |
| ✗ Cosmetic Surgery | ✗ Health Club Dues | ✗ Nutritional Supplements |
| ✗ Dancing Lessons | ✗ Health Coverage Tax Credit | ✗ Personal Use Items |
| ✗ Diaper Service | ✗ Health Savings Accounts | ✗ Swimming Lessons |
| ✗ Electrolysis or Hair Removal | ✗ Household Help | ✗ Teeth Whitening |
| ✗ Flexible Spending Account | ✗ Illegal Operations and Treatments | |
| ✗ Funeral Expenses | ✗ Maternity Clothes | |
| | ✗ Veterinary Fees | |

This list is not all-inclusive; additional expenses may qualify, and the items listed above are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to [Publication 502](#) or consult a tax professional.

HSA State Taxation: There are currently three states that, unlike the federal government, subject your HSA contributions (employee and employer) to state income taxes. The three states are New Jersey, California and Alabama. Similarly, these three states also subject earnings (interest and capital gains) on your HSA to state taxation. There are currently two other states, New Hampshire and Tennessee, that subject earnings on the account (but not the contributions) to state taxes. Tax laws are subject to change. Please contact your state tax authority or consult with a tax advisor to confirm the details for your state.

Flexible Spending Accounts (FSA)

Section 125 Plan

An FSA allows you to place money in a tax-sheltered, short-term account for use in paying for approved healthcare expenses. Enrollment occurs before the beginning of each plan year, or for new employees, during your initial enrollment period. **You must enroll each year** in order to participate in the Healthcare and Dependent Care Reimbursement Accounts. The amount you designate will be taken from your paycheck in equal amounts throughout the plan year. Keep your receipts and Explanation of Benefits (EOBs) in the event that **NAVIA BENEFIT SOLUTIONS** or the IRS requests additional information on your transaction.



Limited Purpose Health Care FSA

- ✓ Contribution Limit—**\$3,300** (2025)
- ✓ **Limited Purpose FSA** is for those enrolled in the HDHP (HSA) Plan. You are eligible to contribute to an FSA and use the funds for dental and vision expenses not covered by the plan.
- ✓ The FSA contribution will be deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the FSA, you effectively adjust your annual taxable salary.
- ✓ **Contributions available first day of new plan year.**

General Purpose Health Care FSA

- ✓ Contribution Limit—**\$3,300** (2025)
- ✓ **General Purpose Health Care FSA** is for those **NOT** enrolled in the HDHP HSA Plan but having a regular PPO plan elsewhere. You are eligible to contribute to an FSA and use the funds for medical, dental and vision expenses not covered by the plan.
- ✓ The Health Care FSA contribution will be deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the FSA, you effectively adjust your annual taxable salary.
- ✓ **Contributions available first day of new plan year.**

Limited and General Purpose Health Care FSA Rollover Provision

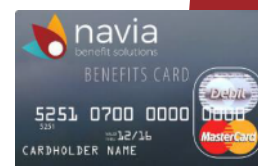
- ✓ Up to \$660 of 2025 unused FSA dollars can be used to reimburse 2024 eligible FSA expenses.
- ✓ Claims must be incurred between July 1, 2025 and June 30, 2026.
- ✓ These claims may be submitted for reimbursement between July 1, 2025 and September 30, 2026.

Dependent Care FSA

- ✓ Contribution Limit (2025):
 - **\$5,000** if you are a single employee or married filing jointly
 - **\$2,500** if you are married and filing separately
 - **Money only available as contributed via your payroll deductions**

IMPORTANT: Elections cannot be changed during the plan year unless you have a qualified change in family status like birth, death, marriage or divorce. **Unused Health Care FSA amounts in excess of \$660 will be forfeited**, so plan carefully before making your elections.

You will receive a **NAVIA BENEFIT SOLUTIONS** Debit Card as an alternative to submitting paper claims and waiting for reimbursement of eligible Flexible Spending Account (FSA) expenses. The card is simple to use when paying for office visit copays, prescription copays, balances remaining after insurance has paid, and certain “over the counter” health care products. Visit www.naviabenefits.com/participants/resources/benefits-card/ for more information on eligible items.



Life/Accidental Death & Dismemberment

Group Life and AD&D



Plan Year—July 1st through June 30th

Coverage is available through Guardian. Life and AD&D insurance is an important benefit, as it provides your beneficiaries financial protection in the event of a tragic loss.

NAVIA BENEFIT SOLUTIONS provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance and **pays for 100% of the coverage**.

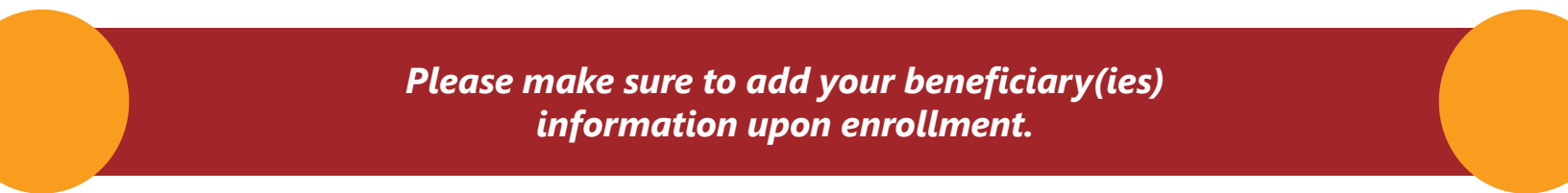
The amount provided by **NAVIA BENEFIT SOLUTIONS** is **two (2) times salary up to a benefit maximum of \$200,000**.

Age Reduction: If you are age 70 or older, the amount of your Group Life Insurance will reduce to the following percentage of its original value:

Age of Employee	Percentage
Age 70	65%
Age 75	45%



Please make sure to add your beneficiary(ies) information upon enrollment.



Life/Accidental Death & Dismemberment

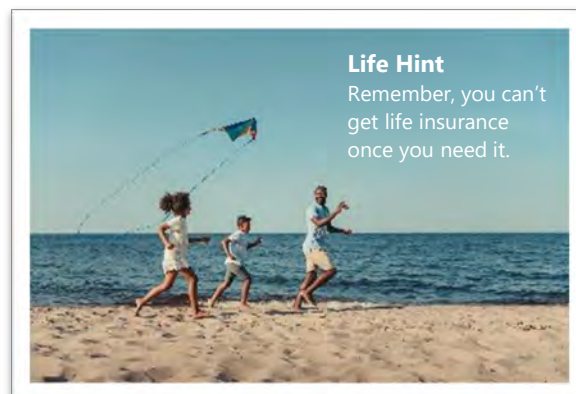
Voluntary Life and AD&D

Plan Year—July 1st through June 30th

If you need additional Life insurance to meet your financial needs, you can purchase **Voluntary Life and AD&D** insurance through after-tax payroll deductions for yourself, your spouse, and your child(ren). Life insurance is about more than paying for memorial services—it's about making sure your family can maintain its standard of living if something happens to you. How much your family needs will depend on your personal situation (other income, monthly expenses, short and long-term debt such as credit card or mortgage expenses, etc.).

Please know you must purchase Voluntary Life Coverage for yourself as an employee in order to purchase coverage for your dependents.

Should you leave the company, you can elect to continue this coverage directly with Guardian. Benefit reductions begin at age 70. Refer to Guardian Benefit Summaries and/or Certificates for additional details.



Life / AD&D Benefit Amount	
Employee	✓ Increments of \$10,000 to a maximum of \$500,000 ✓ Guarantee Issue (GI) Amount \$200,000
Spouse*	✓ Increments of \$5,000 to a maximum of \$100,000 (not to exceed 100% of the employee election) ✓ GI Amount \$50,000
Child(ren)	✓ Options of \$5,000 or \$10,000 (not to exceed 100% of the employee election) ✓ GI Amount: \$10,000

* Spouse rates are based on his/her individual age.

NOTE: Amounts over the GI are subject to completion of a Statement of Health (SOH).

Statement of Health (SOH) Rules

✓ New Entrant:

- **Employee**- If you elect coverage when you are initially eligible, a SOH is required only for any amount over \$200,000.
- **Spouse**- If you elect coverage for your spouse or domestic partner when you are initially eligible, a SOH is required only for any amount over \$50,000.

✓ During Open Enrollment:

- **Employee Coverage**—You can increase your coverage up to the \$200,000 guarantee issue amount without a SOH, so long as you are actively at work. If you wish to increase your coverage over the GI, you must complete the required SOH form.
- **Spouse or Child(ren) Coverage**—You can increase your Spouse or Child(ren) coverage up to the guarantee issue amount without a SOH. If you wish to increase spousal coverage over the \$50,000 GI, you must complete the required SOH form.

- ✓ Coverage for dependents who turn age 26 will end the last day of the month they turn 26, unless their birthday is on the first of the month, in which case coverage would end last day of prior month (day before 26th birthday).

Statement of Health (SOH) is required if you are requesting an amount of coverage that exceeds the maximum guaranteed issue amount in your plan. You will have 30 days to provide a complete SOH. Once your SOH is reviewed by Guardian Life Insurance, they will notify you in writing, approving or denying your request for coverage. **If you do not complete SOH within 30 days or are denied the increase by the carrier, coverage will revert back to your original election(s).**

Disability Income Benefits

If you become disabled and cannot work, no benefit becomes more important to your financial security than Disability Income protection. Disability coverage provides income protection in the event that you experience a non-occupational injury or illness that prevents you from working. You have access to Short-Term Disability (STD) and Long-Term Disability (LTD) insurance through Guardian.



Voluntary STD Insurance

Plan Year—July 1st through June 30th

If you aren't able to work after 7 consecutive days of disability due to an eligible injury or illness, this benefit pays 60% of your weekly pay up to a maximum benefit of \$1,500 per week, for a maximum of 13 weeks. **You pay the full cost of this coverage**, and rates are based on your age and annual base salary as of the effective date of coverage.

If elected, there is a pre-existing condition limitation in which you will not be covered for any disability beginning in the first twelve months caused by the related medical condition that you were diagnosed and/or treated in the three months prior to the effective date. This includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.

If you waive coverage as a newly eligible team member and choose to elect at a later time (such as Open Enrollment), you will be subject to a Statement of Health (SOH).

A complete benefit summary and the cost related to this coverage is available on our Namely Portal.

Voluntary Short-Term Disability (STD) Benefit Summary	
Benefits Begin	✓ 1st day for accident; 8th day for illness
Income Replacement	✓ 60% of your pre-disability earning
Maximum Benefit	✓ \$1,500 Weekly ✓ IMPORTANT: The 'State TDI Benefit Amount' will offset with the 'Voluntary Benefit Amount' so the maximum any employee will receive is \$1,500 per week.
Maximum Benefit Period*	✓ 13 weeks
Pre-Existing Condition	3 months lookback; 12 months exclusion

* Maximum payment period is based on the first day you are disabled, not when benefits begin.



Disability Income Benefits

LTD Insurance



Plan Year—July 1st through June 30th

NAVIA BENEFIT SOLUTIONS provides benefit-eligible employees with LTD benefits. In the event you become disabled due to injury or sickness, LTD income benefits are provided as a source of income on a monthly basis.

This benefit is 100% Employer paid.

A complete benefit summary is available on our Namely Portal.

Long-Term Disability (LTD) Benefit Summary	
Elimination Period	✓ 90 days
Income Replacement	✓ 60% of your pre-disability earning
Maximum Benefit	✓ \$10,000 Monthly
Maximum Benefit Period*	✓ Up to your Social Security Normal Retirement Age (SSNRA)
Pre-Existing Exclusion	3 months lookback; 12 months exclusion

* The age at which the disability begins may affect the duration of the benefits.

Helpful Terms

Elimination Period—It's the period of time you have to wait before benefits begin, starting the day you become ill or injured.

Maximum Monthly Benefit—This is the highest dollar amount a disabled employee can receive on a monthly basis under the LTD plan.

Pre-Disability Earnings—The amount of a policyholder's wages or salary in effect on the day before the disability began.

Maximum Benefit Period—This is a maximum length of time during which benefits will be paid.

Pre-Existing Condition—A medical condition that exists prior to the effective date of the policy and for which a person has received medical care.

Pre-Existing Condition Exclusionary Period—A period of time during which a person's prior medical condition(s) will not be covered by the policy. However, after the pre-existing exclusionary period expires, the condition becomes covered under the coverage.



Commuter Benefits

Commuter benefits allow you to put aside money on a pre-tax basis to pay for work-related commuting and parking expenses. This benefit is only available to you and not your dependents. It consists of two separate benefits, parking and transportation expense reimbursements.

Qualified Parking Expenses

Eligible:

- ✓ Parking expenses at work or near a location from which you commute to work by mass transit, vanpooling in a commuter highway vehicle or carpool by other means
- ✓ Vendor parking lots
- ✓ Vendor parking garages

Ineligible:

- ✓ Parking expenses at or near your residence
- ✓ Expenses incurred that are not for parking at or near your place of business



Transportation Expenses

Eligible:

- ✓ Bus and commuter highway vehicles
- ✓ Mass transit vehicles, Metro, and transit passes (bus, rail, ferry)
- ✓ Pass, token fare card, voucher or similar items for transportation on mass transit
- ✓ Vanpooling—transportation between employee's residence and place of employment in a vehicle that seats at least six adults (excluding the driver) and where at least 80% of mileage is for this purpose

Ineligible:

- ✓ Carpooling
- ✓ Gas
- ✓ Toll fees

How much can I contribute pre-tax each month?

For 2025 you can contribute up to the maximum monthly election amount pre-tax:

- ✓ **Parking Expenses:** Maximum monthly election amount is **\$325.00**
- ✓ **Transportation Expenses:** Maximum monthly election amount is **\$325.00**

How does the Commuter benefits work?

- 1) If you decide to enroll in the plan, estimate the amount you will spend on parking and/or transportation expenses each month. Keep in mind that your contribution will be taken out of your paycheck in equal amounts each pay period on a pre-tax basis.
- 2) Per IRS Regulations:
 - ✓ Transportation fares must be purchased using the Benefit Card.
 - ✓ Parking claims must be submitted within 180 days.
 - ✓ Transportation and Parking are separate plans under Commuter Benefits. Money may not be transferred between the two accounts.
 - ✓ Family members are not eligible to use this plan.
- 3) As you incur transportation and parking expenses throughout the year, you can submit a claim to **NAVIA BENEFIT SOLUTIONS** for reimbursement. You have the option of submitting a claim online OR you can complete a paper claim and fax or mail to Navia. Remember, you can only get reimbursed up to the amount that is available in your account at that time.
- 4) Commuter benefits funds do not expire unless you leave your company. These funds will continue to roll over month to month, year to year, if you're still at the same company. However, when you leave the company, any unused funds in your account will be returned to the company.

Employee Assistance Program (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc will be there to help. The SupportLinc employee assistance program (EAP) is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. SupportLinc provides confidential, professional referrals and **up to five (5) sessions of face-to-face counseling sessions** for a wide variety of concerns, such as:



Anxiety • Depression • Marriage and Relationship Problems • Grief and Loss • Substance Abuse • Anger Management • Stress • Financial Assistance • Legal Assistance • Family Assistance

SupportLinc EAP offers expert guidance to help address and resolve everyday issues, by providing:

- ✓ In-the-moment support—Reach a licensed clinician by phone 24/7/365 for immediate assistance.
- ✓ Short-term counseling—Access up to **five (5) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work related pressures, relationship issues or substance abuse.
- ✓ Financial expertise—Consultation and planning with a licensed financial counselor.
- ✓ Legal consultation—By phone or in-person with a local attorney.
- ✓ Convenience resources—Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.
- ✓ Confidentiality—Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

The web portal and mobile app provides:

- ✓ One-stop shop for program services, information and more.
- ✓ On-demand training to boost wellbeing and life balance.
- ✓ Search engines, financial calculators and career resources.
- ✓ Thousands of articles, tip sheets, self-assessments and videos.

**Download the
mobile app
today!**



Convenient, on-the-go support:

- ✓ Textcoach®—Personalized coaching with a licensed counselor on mobile or desktop.
- ✓ Animo—Self-guided resources to improve focus, wellbeing and emotional fitness.
- ✓ Virtual Support Connect—Moderated group support sessions on an anonymous, chat-based platform.

Start with Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

FOR SUPPORT:

Call: 1.888.881.LINC (5462)
Text: 'Support' to 51230
Visit: www.supportlinc.com
Group Code: **navia**

Wishbone Pet Insurance

NAVIA BENEFIT SOLUTIONS is offering Wishbone Pet Insurance to employees provided through Pet Benefit Solutions. The coverage is underwritten by Clear Blue Insurance Group.

Nobody wants to imagine their pet getting sick or injured—but when it comes to your pet's health, it's best to expect the unexpected.

Enroll in pet health insurance from Wishbone and receive 90% reimbursement on your pet's veterinary care. With a low deductible of \$250, protecting your pet's health and your finances has never been easier!

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Once you file a claim, expect to be reimbursed via mailed check in 5 business days or less. It's that easy!

Wishbone's Base Plan starts at \$12 per month and includes the following:

- ✓ 90% reimbursement
- ✓ \$250 deductible
- ✓ \$25k annual limit
- ✓ Accidents and illnesses
- ✓ Office visits and exam fees
- ✓ Take-home prescription medications

Bonus plan perks—On top of best-in-class coverage and low monthly rates, your Wishbone plan also includes a few extras.

- ✓ **Durable pet ID tag**—ThePetTag provides 25/7 lost pet monitoring service for those adventures that get too far from home.
- ✓ **Free 24/7 vet support**—Midnight counter-surfing catastrophe? Get help anytime from an AskVet veterinarian via live chat.



ENROLL NOW:

<https://www.wishboneinsurance.com/naviabenefits>
Optional wellness coverage is available for an additional cost.

Wellness Reimbursement Plan

Established by **NAVIA BENEFIT SOLUTIONS, INC.** | Administered by **NAVIA BENEFIT SOLUTIONS**

NAVIA BENEFIT SOLUTIONS is proud to be the administrator of your Wellness Reimbursement Plan. This reimbursement plan has been established by **NAVIA BENEFIT SOLUTIONS, INC.** to reimburse you for wellness related expenses.

Benefit Summary

Plan Year: July 1, 2025 – June 30, 2026

Benefit Amount: At the beginning of each month, your Wellness Reimbursement plan will be funded with \$25.00.

Eligible Expenses: You may submit claims for eligible expenses that incurred during the plan year. Spouse and dependent expenses are not eligible.

- ✓ Athletic Event Registration Fees
- ✓ Exercise Videos
- ✓ Fitness/Exercise Classes
- ✓ Fitness Tracking Equipment:
 - Pedometers
 - Heart rate monitors
 - Fitness Bands
 - Watches (must be primarily fitness related)
- ✓ Gym Membership
- ✓ Home Exercise Equipment
- ✓ Massage Therapy
- ✓ Personal Training
- ✓ Sport/Activity League
- ✓ Weight Loss Program

Wellness Plan or FSA?

If you participate in the Health Care FSA, Wellness related expenses will be reimbursed from the Wellness Plan first. Please do not use the **NAVIA BENEFIT SOLUTIONS** Debit Card to pay for Wellness related expenses. The debit card is only tied to the funds in your Health Care FSA. Wellness related expenses will need to be submitted in the form of an itemized statement from the provider. **NAVIA BENEFIT SOLUTIONS** will process your claim and send you a reimbursement.

Claim Submission

- 1) Complete a claim form, itemize your expenses, and list the total amount you are claiming.
- 2) Attach an itemized statement showing the date, type and cost of service and the amount paid.
- 3) Submit the claim form and supporting documentation to **NAVIA BENEFIT SOLUTIONS**. The most efficient way to submit a claim is by using the online claim submission tool or the MyNavia smartphone app for Android or iPhone. You may also submit claims via email, fax or mail. Please use only one method per submission. Allow 2 full business days for your claim to be reviewed and processed once it has been received.
- 4) Reimbursements are processed weekly on Tuesday. Your reimbursement will be directly deposited into your bank account or a check mailed to your home. Direct deposits may take 1 – 2 days to post to your bank account.
- 5) If your employment is terminated or you lose Wellness Plan coverage, you have 0 days after your date of termination to submit claims for expenses incurred prior to your benefit termination date.

Value Added Programs

Teladoc

Enrolled medical plan members are eligible for the Telemedicine program at **no cost**. Telemedicine gives medical plan members **24/7/365 access to a national network of U.S. board-certified doctors**. Members can reach Telemedicine from anywhere—home, work or on the road! Telemedicine doctors diagnose non-emergency medical problems, recommend treatment and can even call in a prescription to the pharmacy, when necessary.

Telemedicine doctors can:

- ✓ Diagnose non-emergency medical problems, such as respiratory infection, ear infections, urinary tract infections, allergies, cold and flu, sore throat, pink eye, etc.
- ✓ Recommend treatment
- ✓ Call in a prescription to your pharmacy of choice, when necessary



First time users will be asked to set up an account where you will be asked to complete questions similar to a first visit to a doctor's office. The doctor reviews your medical history then contacts you, listens to your concerns, and asks questions. For the same cost as an office visit with your primary care provider per consultation, Telemedicine is a cost-effective alternative to an urgent care center or emergency room visit. Register today so you'll be ready to use a Telemedicine service when and where you need it. Three ways to register:

Online

The fastest and easiest option. Log into MyDrConsult.com and complete the "My Medical History" section.

Mobile app

Log into your account on your mobile device and complete the "My Health Record" section. Visit Teladoc.com/mobile to download the app.

Call Teladoc

Call Teladoc if you would like a customer service representative to help you complete your medical history over the phone.

Talk to a doctor anytime



MyDrConsult.com



Facebook.com/Teladoc



1-800-DOC-CONSULT (362-2667)



Teladoc.com/mobile

WillPrep Services

Help protect the ones you love

WillPrep Services offer a range of will preparation services. For eligible members with **voluntary term life plans**, the services include online planning documents, a resource library and access to professionals to help with issues related to:

- Advanced health care directives
- Estate taxes
- Executors & probate
- Financial power of attorney
- Getting organized
- Guardianship & conservatorship
- Healthcare power of attorney
- Living wills
- Trusts
- Wills

Estate planning documents

Members have access to a number of necessary planning documents such as wills, healthcare power of attorney, financial power of attorney and living wills. Documents are easy to use and understand.

Resource library

Learn the importance of estate planning, organizing your personal affairs and protecting your loved ones through unlimited access to a dedicated legal/financial website. Each member can gain access to a glossary of legal terms, a variety of legal articles and guides as well as legal Frequently Asked Questions (FAQs).

Access to estate planners

The complexities of estate planning can be overwhelming, especially during times of need. Each member has access to telephonic consultations with an estate planner.



Expanded discounted estate planning package options* include:

- \$100: attorney assisted will package: attorney assisted will; one advance medical directive/living will; one health care agent form; one durable power of attorney
- \$179: couples will package: two simple wills; two advance medical directives/living wills; two health care agent forms; two durable powers of attorneys
- \$649: individual trust package: one A/B revocable trust with a pour-over will; one advance medical directive/living will; one health care agent form; one durable power of attorney
- \$999: couples trust package: one A/B revocable trust with a pour-over will for each spouse; two advance health care directives/living wills; two health care agent forms; two durable powers of attorney

Attorney assisted will and trust preparation

While many people feel comfortable using the services' interactive web-based program to develop their own will free of charge, others prefer to have an attorney actually prepare the will or trust. The option for an attorney prepared will is available for a modest charge.

We are here to help:
willprep.uprisehealth.com

- Username: WillPrep
 - Password: GLIC09
- Call 1-877-433-6789

* Package cost paid by the employee. Package options available as of 1/1/22. WillPrep Services are provided by Uprise Health, and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of WillPrep Services. Guardian is not responsible or for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WillPrep Services at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer. Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation. Guardian® is a registered trademark of The Guardian Life Insurance Company of America. ©Copyright 2024 The Guardian Life Insurance Company of America.

Contacts

Your Carriers

Coverage	Vendor / Carrier	Contact Information
Medical	Benefits Plan Administrators (BPA)	Phone: (800) 236-7789 Website: www.bpaco.com
Dental / Vision	Navia Benefit Solutions	Phone: (425) 452-3470 Website: HR Tab within Confluence
Life / AD&D and Disability	Guardian Life Insurance Company	Phone: (800) 525-4542 (800) 268-2525 Website: www.guardiananytime.com
Flexible Spending Account (FSA) / Commuter Benefits	Navia Benefit Solutions	Phone: (800) 669-3539 Website: www.naviabenefits.com
Employee Assistance Program (EAP)	SupportLinc	Phone: (888) 881-LINC (5462) Text: 'Support' to 51230 Website: www.supportlinc.com Group Code: navia
Pet Insurance	Pet Benefit Solutions	Phone: (800) 891-2565 Website: www.petbenefits.com Email: customercare@petbenefits.com

Your Human Resources Team

Contact Name	Title	Contact Information
Jack Tarasewicz	VP Human Resources	Phone: (425) 452-3470 Email: JTarasewicz@naviabenefits.com
Jim Reynoso	Human Resources Manager	Phone: (760) 705-3052 Email: JReynoso@navia.com

Your Hauser Team

Contact Name	Contact Information	Contact Information
Matt Otto Managing Director	Email: motto@thehausergroup.com	Matt works closely with Navia and Hauser Team to provide consultation on benefit goals and future direction to develop and implement effective strategies. Ensures health plan runs smoothly and efficiently.
Lina Colon Client Executive	Email: lcolon@thehausergroup.com	Lina is responsible for benefit plan presentations to members and assisting in executing benefit initiatives. Also, a day-to-day contact for plan questions, eligibility, and assistance in resolving an escalated claim.

Important Notices

Notice of Patient Protections & Prior Authorization Procedures

Your **BPA PLANS** allow you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing \$500 or more. Contact **BPA** Customer Service using the number on the back of your medical ID card or online at www.bpaco.com to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- ✓ 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.

The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, 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). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

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

ALABAMA—Medicaid	CALIFORNIA—Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA—Medicaid	COLORADO—Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS—Medicaid	FLORIDA—Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

Important Notices

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

GEORGIA—Medicaid	MAINE—Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
INDIANA—Medicaid	MASSACHUSETTS—Medicaid and CHIP
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA—Medicaid and CHIP (Hawki)	MINNESOTA—Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS—Medicaid	MISSOURI—Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY—Medicaid	MONTANA—Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA—Medicaid	NEBRASKA—Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Important Notices

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

NEVADA—Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	SOUTH CAROLINA—Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE—Medicaid Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218	SOUTH DAKOTA—Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY—Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	TEXAS—Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK—Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	UTAH—Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA—Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	VERMONT—Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA—Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	VIRGINIA—Medicaid and CHIP Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA—Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	WASHINGTON—Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON—Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	WEST VIRGINIA—Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-Free Phone: 1-855-MyWVHIPP (1-855-699- 8447)
PENNSYLVANIA—Medicaid Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	WISCONSIN—Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND—Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	WYOMING—Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Important Notices

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

To see if any other states have added a premium assistance program since January 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notice of Privacy Practices

BPA is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting BPA.

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

Important Notices

Important Notice from NAVIA BENEFIT SOLUTIONS about Your Prescription Drug Coverage and Medicare for plans:

✓ **BPA BASE HRA PLAN** **BPA HSA PLAN**

✓ **BPA BUY UP PPO PLAN**

Medicare Part D Prescription Drug Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **NAVIA BENEFIT SOLUTIONS** 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. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **NAVIA BENEFIT SOLUTIONS** has determined that the prescription drug coverage offered by the **BPA PLANS** 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 15th to December 7th.

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

Since the coverage under your **BPA PLAN** is creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **BPA PLAN** coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current **NAVIA BENEFIT SOLUTIONS** coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid-year qualifying event.

Important Notices

Medicare Part D Prescription Drug Notice (continued)

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- ✓ Visit www.medicare.gov
- ✓ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- ✓ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 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).

Date: 07/01/2025

Name of Entity/Sender: **NAVIA BENEFIT SOLUTIONS**

Office Contact/Position: Jack Tarasewicz / VP of Human Resources

Phone: (425) 452-3470

Address: 707 S GRADY WAY, STE 350, RENTON, WA 98057-3246

Important Notices



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2025)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer..

What is the Health Insurance 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

NOTE: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may 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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Your Human Resources Department**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ 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.

Important Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name NAVIA BENEFIT SOLUTIONS	4. Employer Identification Number (EIN) 91-1467758	
5. Employer Address 707 S GRADY WAY STE 350	6. Employer Phone Number (425) 452-3470	
7. City Renton	8. State WA	9. Zip Code 98057
10. Who can we contact about employee health coverage at this job? Jack Tarasewicz		
11. Phone Number (if different from above)	12. Employer Email Address jtarasewicz@naviabenefits.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

- ☒ All employees. Eligible employees are:

Full time employees

- ☐ Some employees. Eligible employees are:

- With respect to dependents

- ☒ We do offer coverage. Eligible dependents are:

- Legal Spouses
- Domestic Partners (Same and Opposite Sex)
- Dependents up to age 26

- ☐ We do not offer coverage.

- ☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Important Notices

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ **Yes** (Go to question 15)

☐ **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee (don't include family plans):**
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **\$69.00**

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

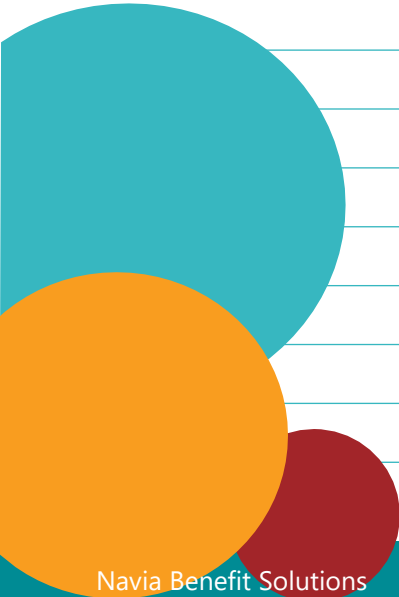
a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).



Lined area for taking notes, consisting of horizontal blue lines on a white background.





707 S GRADY WAY
STE 350
RENTON, WA 98057-3246

The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.