2025

Benefits Guide

ParametriX

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BENEFITS OVERVIEW

Parametrix is proud to offer a comprehensive benefits package to our valued employee-owners and their families.

This Benefits Guide will help you learn more about your benefits, review highlights of the available plans and make selections that best fit your lifestyle and budget. You can contact Human Resources or call a Benefit Advocate at Gallagher Benefit Services for help in understanding your benefits and completing your enrollment. Contact information is listed at the end of this guide under "Your Benefit Contacts". Detailed information about each plan offered can be found on https://c2mb.ajg.com/parametrix/.

To assist you in making decisions regarding your healthcare coverage, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, as required by Healthcare Reform regulations. The SBCs are available on the benefits portal. If requested, a paper copy is also available, at no cost, by contacting Human Resources.

Benefits Offered

- A comprehensive PPO medical plan, with access to a broad network of providers and a prescription drug benefit
- A High Deductible Health Plan (HDHP) medical option to use in conjunction with a Health Savings Account (HSA)
- Vision benefit with exam and hardware allowance
- Dental benefit of $2,000 per person per year (including orthodontia)
- Wellness Program
- Short-Term (STD) and Long-Term (LTD) disability insurance
- Life and Accidental Death & Dismemberment (AD&D) insurance
- Flexible Spending Accounts (FSA) for tax savings on health and dependent care expenses
- Employee Assistance Program (EAP)
- Behavioral Health Support
- Voluntary Life, AD&D, and Long-Term Care insurance options
- Gallagher Marketplace for discounted auto, home, pre-paid legal, ID theft, pet insurance and other perks

Important

If you (and/or your dependents) have Medicare, or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 39 for more details.

WHAT'S NEW FOR 2025?

As of January 1, 2025, there will be some changes to the Parametrix Employee Benefits Program. Below is a summary of the key changes. Please review and contact Human Resources if you have questions.

Medical

- Changes to Medical PPO: Increased deductible from $1,250 to $1,500 per covered person, and increased in-network out-of-pocket maximum from $7,000 to $8,000 per covered individual.
- Change the High Deductible Health Plan's deductible to better align with minimum deductible requirements set by the IRS ($2,000 individual/$4,000 family).
- Coming soon - EOBs (Explanation of Benefits) from Premera will be moving to completely electronic during the spring of 2025. More information to come on this transition.

Health Savings Account (HSA)

- Parametrix contribution towards the HSA has increased to $1,250 employee only and $2,500 for employee +/ family coverage.
- **Health Savings Account (HSA) Contribution Limit**: The annual pre-tax contribution limit for this benefit will increase to $4,300 for employee only, and $8,550 for employee / family coverage.

Flexible Spending Account (FSA)

- Increased Healthcare FSA Maximum to $3,300 and increased allowed carryover maximum to new plan year of $660 beginning with carryover on the 2025 FSA plan.

Voluntary Long Term Care

Rate Increase effective January 1st. A separate open enrollment opportunity will be held following our open enrollment. .

- You can review your coverage and updated premiums through Gallagher vChoice.
- If employees wish to make a change to their plan to offset the increase, the new plan selected will be based upon the age as of 1/1/2025, rather than the age at initial effective date. Employees may find the cost to be even higher, while decreasing their coverage.
- Employees who do not wish to make a change should NOT unlock the benefit, rather simply view, as that is what their new rate will be. If an employee unlocks and keep the same benefit, it will recalculate based upon age as of 1/1/2025, rather than their age at initial effective date.
- If an employee wishes to cancel their coverage, the employee should complete the change request form.
- New elections for late entrants must submit both an application and EOI.
- New elections for new hires need only submit the application.
- All dependent elections for new and late entrants require both the application and EOI.
- All forms for new, change or cancelations should be routed to HR/Benefits directly for processing.

*Forms, application and EOI available in Gallagher vChoice

For more details on your plan coverage, please review the plan documents from the carrier available at https://c2mb.ajg.com/parametrix/

ENROLLMENT CHECKLIST

Please follow the steps below to choose your benefits and enroll.

1. Gather everything you will need.

- Understand your personal healthcare costs. Log onto your member portal at www.Premera.com to view past usage and determine future plan enrollment
- Social security numbers for you and family members whom you want to enroll in your benefits
- Dates of birth for your family members

2. Choose your health & life benefits.

Take the time to review the benefit outlines provided in this guide. This will help you understand the plans offered and how they will fit your lifestyle and budget.

3. Decide if you want to contribute to the Flexible Spending Account (FSA).

Use the online calculator at www.NaviaBenefits.com to help determine how much money to pledge into your Flexible Spending Account (FSA). Participating in an FSA plan allows you to save money on taxes when paying for medical and dependent care expenses. Please see the Flexible Spending Account section in this guide for more details.

ALL EMPLOYEES WISHING TO PARTICIPATE IN THE FSA PLAN FOR THE 2025 PLAN YEAR MUST LOG INTO ADP TO MAKE ANNUAL ELECTIONS.

Please note those enrolled in the HDHP medical plan are not eligible to enroll in the Healthcare FSA, however they may participate in the Dependent Care FSA.

4. Choose your voluntary benefits - Gallagher vChoice.

Enrollment for voluntary benefits is made through an online enrollment platform, www.GallaghervChoiceEnroll.com. If you are already enrolled in voluntary benefits, and **do not wish to make open enrollment changes**, it is not necessary to log into the online enrollment platform, however, is recommended to review premium amounts. Only complete the online enrollment if you are enrolling for the first time or changing your voluntary benefits selection. Please see page 35 for log-in information.

5. Complete benefit election through the ADP portal.

Unless you are making open enrollment changes (i.e. adding/removing a spouse/domestic partner or child or waiving coverage), there is no need to log into ADP.

If you require changes, log into ADP and be sure to note family members who you want covered (spouse/domestic partner and/or children) and elect either the High Deductible Health Plan (HDHP) with Parametrix funded Health Savings Account or Parametrix Preferred Provider Organization (PPO) medical plan. If you fail to make a medical plan election, you will be automatically enrolled in the PPO medical plan. In addition, your plan election is binding until the 2026 open enrollment.

NEW EMPLOYEES: You must select your benefits within 30 days of becoming eligible by making your elections in ADP. Your new benefits will become effective the first of the month following or coinciding with your date of hire.

WHO IS ELIGIBLE?

All regular full-time employees scheduled to work (30+ hours per week) and part-time employees scheduled to work 20 or more hours per week are eligible for benefits. Coverage will begin on the first of the month following or coinciding with your date of hire. You may enroll your eligible dependents for medical, dental and vision, as well as some of the voluntary benefits. All benefit eligible employees and their dependents can obtain Employee Assistance Program (EAP) services regardless of enrollment in the medical and/or dental plans.

Your eligible dependents include:

- Your legal spouse or domestic partner
- Your children up to the age of 26 (this includes your domestic partner's children and step children in your custody)
- Any overage dependent child who is incapable of self-support because of a physical or mental disability and meets carrier requirements for coverage

Domestic Partners & Taxation

Parametrix extends health benefits to employees' domestic partners. However, the value of these benefits must be included in employee's gross income, subject to federal income tax and FICA tax; unless the domestic partner is the employee's qualified IRS tax code 152 dependent. A domestic partner can be same or opposite sex.

In order to qualify as a domestic partner, the following criteria must be true:

- Each 18 years of age or older;
- Share a close personal relationship and are each other's sole domestic partners;
- Responsible for each other's common welfare;
- Not legally married to anyone;
- Not related by blood closer than would bar marriage in the State of Washington;
- Currently share the same regular and permanent residence; and
- Jointly share financial responsibility for "basic living expenses" including the cost of food, shelter, and other costs such as medical expenses.

Making Changes to your Benefits

You may make changes to your benefit elections once a year during the annual Open Enrollment period. All coverages you select will be effective for a full calendar year, unless you have a "qualified change in status" or leave employment.

Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you experience a qualifying event that changes your family status, you can make benefit election changes by submitting a Healthcare Enrollment & Change Form to Human Resources within 30 days of the change. The change to your benefits must be consistent with the change in family status. For example, if you have a new baby you can enroll the child as a dependent under your current health plans, but you may not remove another already covered dependent.

The effective date of the change will take place on the first of the month following the qualifying event, except for the birth or adoption of a child. For birth or adoption, the effective date will take place on the date of birth for a new baby, or the finalized adoption date of a dependent.

SPECIAL ENROLLMENT RIGHTS

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

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 30 days after that coverage ends or after you become eligible for premium assistance.

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

REMEMBER!

You must notify Human Resources and submit a Healthcare Enrollment & Change Form within 30 days if you have a change in family status.

Qualified change in status examples:

- Birth or adoption of a child
- Loss of your or a dependent's coverage under another plan
- Change in marital status, including legal separation

Please see your HR Business Partner for specific details.

PREMIUM COST OUTLINE

Parametrix continues to offer a competitive benefits program to eligible employees and their families. Additionally, the company covers the larger portion of the premiums for the medical, Rx, vision and dental benefits. Please see the applicable premium contribution amounts below.

Benefit Cost Outlines

Medical, Rx & Vision	Total Monthly Cost	Parametrix Monthly Cost	Employee Monthly Cost	Employee Bi-weekly Cost
PPO Plan				
Employee	$841.65	$745.65	$96.00	$48.00
Employee + Spouse/Domestic Partner	$1,851.62	$1,323.62	$528.00	$264.00
Employee + Child(ren)	$1,514.96	$970.96	$544.00	$272.00
Employee + Family	$2,524.94	$1,650.94	$874.00	$437.00
HDHP*				
Employee	$641.15	$641.15	$0.00	$0.00
Employee + Spouse/Domestic Partner	$1,410.54	$1,168.54	$242.00	$121.00
Employee + Child(ren)	$1,154.08	$944.08	$210.00	$105.00
Employee + Family	$1,923.49	$1,471.49	$452.00	$226.00

Dental Plan	Total Monthly Cost	Parametrix Monthly Cost	Employee Monthly Cost	Employee Bi-weekly Cost
Dental Plan				
Employee	$54.45	$54.45	$0.00	$0.00
Employee + Spouse/Domestic Partner	$119.79	$90.79	$29.00	$14.50
Employee + Child(ren)	$98.01	$73.01	$25.00	$12.50
Employee + Family	$163.35	$110.35	$53.00	$26.50

*Parametrix also contributes amounts to those enrolling in the HDHP in conjunction with a Health Savings Account.

Employees receive 26 paychecks per year; however, deductions for the healthcare plan are only done for 24 of the 26 annual paychecks.

Employee Opt out option (Medical/Vision/Rx) Plan

Employees have the option of opting out of the healthcare (medical/vision/Rx) plan.

- If you choose to opt out of the Healthcare Plan, you are opting out of the benefits for the entire family.
- Creditable healthcare coverage must be in place through your spouse's plan, a retirement plan, military plan, etc. for approval to opt out of the Healthcare Plan. Proof of other creditable coverage must be provided.
- You will receive $100 per paycheck up to a maximum of 24 paychecks per year once you are approved to opt out of the Healthcare Plan. Please be aware that this benefit will be taxed.
- Should you experience a qualifying family status change during the year, you will be eligible to elect coverage.
- Employees opting out of the Healthcare Plan may enroll themselves (and their dependents) in the dental plan.

Parametrix continues to provide Life/AD&D, Short-Term disability and Long-Term disability insurance benefits, as well as an EAP at no cost to you!

MEDICAL BENEFITS OVERVIEW

Administered by Premera Blue Cross

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Parametrix offers you the choice of two medical plans supported by a very large network of medical care providers. These plans provide excellent coverage for preventive services, such as routine physical exams and immunizations, that are very important to your and your family's health. Prescription drug and vision coverages are also included with the medical plans.

PPO Plan & HDHP Plan

***The PPO (Preferred Provider Organization)* plan** offers a wide choice of providers. You can select to use a provider in the Heritage/Heritage Plus 1 network or any other provider for your healthcare services. If you choose a network provider, your cost will be less (please see the plan highlights on page 11 for the difference in coverage between in-network and out-of-network). You do not need a referral for specialist care; however, some services will require a prior authorization.

The HDHP is a High Deductible Health Plan that has the same network of providers as the PPO Plan explained above and work in a similar manner. The main differences are that the deductibles are higher for the HDHP and apply for most services (with the exception of preventive care and certain preventive medications). However, the premiums are lower and these plans are compatible with a Health Savings Account (HSA) which allows you to set aside pre-tax funds to pay for future healthcare needs. These funds are yours and any unused amounts will roll-over from year to year. Additionally, if you enroll in the HDHP, **Parametrix makes an annual contribution of $1,250 for individual coverage and $2,500 for family coverage to your HSA.**

Network Providers

Both plans offer a wide choice of network providers. You do not need a referral for specialist care. You can find preferred providers at the web addresses below. It is important to remember to use in-network PPO providers to keep your out-of-pocket expenses as low as possible.

- In Washington State: www.Premera.com *Heritage Network*
- All other states or when traveling outside the United States: www.BCBS.com *BlueCard PPO Network*

Facility Charges

It has become common for doctors' offices, urgent-care clinics and radiology facilities, to charge an add-on fee called a "facility charge". This is a practice some providers in our area are choosing to follow by adding on to their standard fees, and this can come as a surprise to you. Facility charges are billed as hospital services and are subject to the deductible and coinsurance under most insurance plans, including the Parametrix medical plans.

Facility charges are not specifically identified in Premera's Summary Plan Description because they are billed under hospital services. It is important to note that these add-on fees are a result of a facility or doctor's office business practice, and not Premera or our health plan. Because of continued consumer frustration and complaints to the Office of the Insurance Commissioner, legislation was passed in the State of Washington to protect consumers. Providers in Washington must disclose the additional facility fee at the appointment time if this is their business practice.

How Can I Avoid Extra Charges from my Providers?

Here are some steps you can take to protect yourself from paying too much:

- Ask in advance about your doctor's billing practices and if they add on facility charges prior to making your appointment.
- If your doctor does practice in a clinic that levies a hospital-facility fee, ask if the physician also works out of another office that might not involve the extra charge.
- Research contracted urgent-care clinics in your area before you need one, so you know about their billing practices.

MEDICAL PLAN: KEY TERMS

In general, medical plans feature an annual deductible you must satisfy each year, copays and/or coinsurance for many services, and an out-of-pocket maximum. Understanding these plan features is key to understanding your medical benefits, particularly the amounts you are responsible for paying, and what the plan covers.

Network

An insurance carrier's list of preferred and contracted providers and facilities. These providers have agreed to extend services to the carrier's members at a lower fee, based on a contract.

In-Network

When a provider is "In-Network" he/she has a contract with the insurance carrier and has agreed to provide members with services at a lower, contracted fee. Seeking in-network care will result in less out-of-pocket cost for the member, as the plan will cover more of the cost of healthcare services.

Out-of-Network

When a provider is "Out-of-Network" he/she does not have an agreement with the insurance carrier and can bill members for services that are beyond what the plan covers. Seeking care from out-of-network providers results in more out-of-pocket cost for the member.

Copay (Copayment)

This is a flat fee paid for a healthcare service or prescription drug, based on the plan's terms. For example, the Premera Blue Cross PPO plan requires a $25 copay for diagnostic office visits.

Coinsurance

The percentage of the charges a member is responsible for paying, typically after the plan deductible has been met for the year. For example, the plan pays 80% and you pay 20%.

Calendar Year

Refers to the time period from January 1 to December 31.

Deductible

This is the amount a member pays for applicable healthcare services, before the plan pays its portion of the cost.

Aggregate

Aggregate means that a plan's family deductible must be completely met, by one or more members of the family unit, before the plan pays its corresponding portion of the coverage. This applies to the HDHP option.

Out-of-Pocket Maximum (OOPM)

This is the maximum cost a member will pay out of pocket for covered medical services during the plan's effective period (i.e. calendar year). Once the OOPM has been met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

Preventive Care

Measures taken to prevent diseases. This includes routine screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to the member.

Virtual Care

This is a term that encompasses all the ways healthcare providers remotely interact with patients. Providers may use live video, audio and instant messaging to communicate with their patients remotely.

Explanation of benefits (EOB)

The statement a member receives from the insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount the member owes the provider (if any).

Prior Authorization

This is a requirement that a physician obtain approval from the medical plan carrier to prescribe a specific medication for a member or provide a specific healthcare service. PA is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance carrier.

Generic drug

A prescription drug made and distributed after the brand name patent is expired. These are generally available at a much lower cost than brand name prescriptions.

MEDICAL BENEFITS

Administered by Premera Blue Cross

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO PLAN		HDHP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited		Unlimited	
Calendar Year Deductible (CYD)	$1,500 Individual / $3,000 Family		$2,000 Individual / $4,000 Aggregate*	
Annual Out-of-Pocket Maximum	$8,000 Individual $16,000 Family	$10,000 Individual $20,000 Family	$5,000 Individual $10,000 Family	$6,500 Individual $13,000 Family
Coinsurance	20%	40%	20%	40%
OFFICE VISITS				
Primary Care	$25 copay	40% after CYD	20% after CYD	40% after CYD
Specialist	$25 copay	40% after CYD	20% after CYD	40% after CYD
Preventive Care *Routine exams, x-rays/tests, immunizations, well baby care and*	Covered 100%	40% after CYD	Covered 100%	40% after CYD
HOSPITAL SERVICES				
Emergency Room	$75 copay + 20% after CYD Copay waived if admitted to hospital		20% after CYD	
Inpatient *Semi-private room/board, ICU, CCU, ancillary charges*	20% after CYD	$200 copay per admission + 40% after CYD	20% after CYD	40% after CYD
Outpatient Hospital Surgical Facility	$50 copay	40% after CYD	20% after CYD	40% after CYD
Ground Ambulance Service	20% after CYD		20% after CYD	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Inpatient Services	20% after CYD	$200 per admission + 40% after CYD	20% after CYD	40% after CYD
Outpatient Services	$25 copay	40% after CYD	20% after CYD	40% after CYD
PHYSICAL THERAPY *Must be medically necessary— Includes massage therapy*				
Inpatient Facility	20% after CYD	$200 per admission + 40% after CYD	20% after CYD	40% after CYD
Outpatient	$25 copay	40% after CYD	20% after CYD	40% after CYD
MATERNITY SERVICES				
Professional Care	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Hospital	20% after CYD	$200 copay + 40% after CYD	20% after CYD	40% after CYD
Birthing Center	$50 copay per visit	$200 copay + 40% after CYD	20% after CYD	40% after CYD

*CYD = Calendar Year Deductible / **Calendar year** = January 1 through December 31*
**See page 10 for definition of an aggregate deductible*

	PPO PLAN		HDHP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
OTHER SERVICES				
Infertility *$20,000 lifetime limit for eligible employee/spouse/domestic partner members*	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Hearing Exam *To determine loss of hearing* *1 per calendar year*	$25 copay *This copay does not apply to OOPM*		20% after CYD	40% after CYD
Hearing Hardware *$5k maximum for 3 years*	20% after CYD	20% after CYD	20% after CYD	20% after CYD
Acupuncture must be medically *necessary and obtained from a licensed /certified provider* *12 visits per calendar year*	$25 copay	40% after CYD	20% after CYD	40% after CYD
Chiropractic Care *30 visits per calendar year*	$25 copay	40% after CYD	20% after CYD	40% after CYD
Durable Medical Equipment	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Orthotics *Up to $300 per calendar year*	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Outpatient Lab and X-Ray	20%	40%	20% after CYD	40% after CYD

Note: This benefit outline is for illustrative purposes only. Actual claims paid are subject to the terms and conditions of the contract.

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HEALTH SAVINGS ACCOUNT (HSA)

Administered by Optum Financial

Premera has partnered with Optum Financial to administer you HSA banking account. You can manage your account by logging into your Premera account and selecting your "Personal Funding Account".

A health savings account (HSA) is a tax-advantaged healthcare savings account available if you enroll in the High Deductible Health Plan (HDHP). You are able to contribute to the HSA through payroll deduction, free of federal taxes. Parametrix also contributes to the account. Think of it as a 401(k) for healthcare, only there is no penalty for using it at any time for eligible expenses. Here's how it works:

What is a Health Savings Account (HSA)?

- You elect how much money to contribute to the HSA up to the maximum (set by the IRS annually). This amount can be changed throughout the year by notifying payroll.
- A welcome kit with a credit card and optional investment information will be mailed to your home after enrollment.
- Once money is deposited, you can use your card to pay for eligible medical, dental, vision and Rx expenses or leave the money in the account to grow.
- Withdrawals are always tax free for eligible expenses.
- HSA money can be used for all of your eligible tax dependents, regardless of enrollment on your HDHP plan.
- HSA funds roll over and accumulate year-to-year.
- If you switch jobs, or retire, the HSA goes with you. It's your account!
- Even if you enroll in a non-HDHP plan in the future, you can always use the funds in the HSA to pay for qualified expenses tax free. However, contributions to the HSA must stop once you enroll in a non-HDHP.
- At age 65, you are able to use the funds for non-qualified expenses without a penalty, but will be subject to federal income tax. However, contributions into the HSA account are no longer allowed.

You are eligible if you:

- Are covered by a qualified High Deductible Health Plan (HDHP);
- Are not covered under any other health plan, including Medicare or Tricare.
- Are not covered by your own or a spouse's general purpose FSA or HRA.
- Are not claimed as a tax dependent on another person's taxes.
- Have not received Veteran's Administration health benefits for a non-service connected disability, or used Indian Health Services coverage in the last three months.

Domestic partners are eligible to participate in the HDHP plan, however funds in the HSA can only be used for the domestic partner's eligible expenses if they are an IRS qualified tax dependent.

CONTRIBUTIONS

- Employee and Employer combined contributions cannot exceed $4,300/Individual or $8,550/Family in 2025.
- For individuals age 55 or older an additional amount of $1,000 “catch-up” contributions are allowed in 2025.
- You may contribute the annual maximum amount, regardless of when your coverage begins, if you maintain enrollment in a HDHP for the 12 month period beyond the calendar year in which you first became eligible. Pro-rating of contributions only occurs when the status of an HSA changes from family to single or if your medical coverage with the HSA qualified health plan is terminated.
- Your contributions are tax free in most states (California and New Jersey are exceptions).

How does an HSA work with my HDHP?

When enrolled in a HDHP, the deductible applies first for all medical and prescription services except preventive care and certain prescription medications. Your providers should not require payment up front, but you will have to pay when picking up a prescription. Here’s what to expect:

- Your medical provider will submit a claim to your health plan for the services you received.
- The health plan will then send you an Explanation of Benefits (EOB) outlining what was covered and what your cost sharing is.
- The provider will send an invoice reflecting the amount you owe.
- You can then pay the invoice with money from your HSA. Or, you can leave the money in the HSA to grow and build for the future and pay for the services from other personal funds. Remember to keep your receipts in case the IRS requests them.

HSA Resources

Using your HSA goes beyond paying for bills. An HSA is a great place to build up savings for expenses you have today or will have in the future. If you can afford to pay bills out of pocket and save the money in your HSA for the future, then your HSA balance will grow through interest and investment earnings. That way you’ll have more money for expenses when you need it most – whether that’s a year from now or in your retirement.

What is HSA Saver®?

A way to invest in your future, HSA Saver® has been designed to provide a simplified approach to your HSA investments. Backed by your bank’s experience and insight, HSA Saver® is a powerful tool that just made investing a whole lot easier. After you have reached the required account balance, you can open an HSA Saver investment portfolio. HSA Saver makes investing:

- **Simple**. You decide how much and how often to invest for one low monthly fee, no fund minimums and no trading fees.
- **Fast**. It only takes a few minutes to enroll and get started.
- **Smart**. HSA Saver® is a powerful tool that makes investing a whole lot easier.

Once you have enrolled in a HDHP and your HSA is set up, you can decide how you want your contributions invested (all funds are initially deposited in an HSA Deposit Account at Optum Financial). When your balance reaches the minimum balance set by your HSA Administrator (typically $1,000), you have the option to invest your HSA funds into the HSA Saver® investment portfolio.

For more information on the HSA Saver®, call 800.941.6121.

Employer HSA Contributions

Parametrix will contribute **$1,250 for employee only** coverage and **$2,500 for family coverage** for each employee enrolling in the HDHP with an HSA.

The full amount will be available at the beginning of the plan year.

If joining the plan mid-plan year, the employer contribution amount will be prorated.

PRESCRIPTION DRUG PROGRAM

Administered by Premera Blue Cross

Your plan includes a prescription drug program. The level of coverage depends on whether the drug is generic, preferred brand name, or non-preferred brand name, and which medical plan you are enrolled in. Your out-of-pocket cost is lowest when you buy generic drugs and highest when you buy non-preferred brand name drugs.

Premera covers a broad list of drugs. To determine whether your drug is generic, preferred or non-preferred brand name, please check the online list at www.Premera.com. You can also find a list of in-network pharmacies on this site. The drug list is updated periodically to ensure that newer, more effective drugs are listed. When filling a prescription, present your Premera Blue Cross member ID card to any participating pharmacy. If using an out-of-network pharmacy, you will need to pay the drug cost out-of-pocket and then submit a claim form to Premera to be reimbursed for the amount of coverage.

Mail Order Prescription Drugs Through Express Scripts

If you take prescription drugs on an ongoing, maintenance basis, you can save money by using the mail-order program and ordering a 100-day supply at a time. To take advantage of this money saving program, ask your doctor to write you a prescription for your medication of at least a 100-day supply. Send in the paper prescription along with the order form to the Express Scripts address on the mail-order form. You can download the form online at www.Express-Scripts.com. This site requires you to log on, then choose the "mail service refills" tab where the mail order form is located. Once your prescription is setup in the system (with your original paper prescription), you can conveniently refill the prescription online or over the phone.

PPO PLAN	
Formulary / Preventive	B3 / PV Core Plus
Deductible	Waived
AT PREMERA IN-NETWORK PHAMACIES ONLY	
Maximum Supply	100-day supply
Generic	$10 copay per 1 month supply
Preferred Brand	$30 copay per 1 month supply
Non-Preferred Brand	$50 copay per 1 month supply
THROUGH EXPRESS SCRIPTS MAIL-ORDER PHARMACIES ONLY	
Maximum supply	100-day supply
Generic	$25 copay
Preferred Brand	$75 copay
Non-Preferred Brand	$125 copay

HDHP PLAN	
Formulary / Preventive	Open A1 / PV Core Plus
Deductible	Medical deductible applies
AT PREMERA IN-NETWORK PHAMACIES ONLY	
Maximum Supply	100-day supply
Generic*	20% after CYD
Brand Name	20% after CYD
THROUGH EXPRESS SCRIPTS MAIL-ORDER PHARMACIES ONLY	
Maximum supply	100-day supply
Generic	20% after CYD
Brand Name	20% after CYD

To locate contracted pharmacies, log onto www.Premera.com.

*Specific preventive drugs are covered in full when obtained at in-network pharmacies. The preventive generic drug list can be found on the Premera website.

How can I save money on prescription drugs?

Drugs losing their patents mean cost savings to you! Brand name drugs like Lipitor and Singulair have already lost their patent. Ask your doctor about generic alternatives.

VISION BENEFITS

Administered by Premera Blue Cross

Regular eye examinations not only determine your need for corrective eyewear, but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. Each enrolled member receives the benefits illustrated below.

To find in-network vision providers visit www.Premera.com, click on "Find a doctor" and select the Heritage & Heritage Plus 1 network option. If you are outside of Washington or Alaska, you can visit www.BCBS.com to find a provider through the BlueCard Program.

Calendar year = Jan 1 - Dec 31	In-Network	Out-of-Network*
Basic Examination 1 per calendar year	$25 copay	$25 copay
Hardware for members age 19 and older *Frames, lenses and contact lenses*	Covered in full up to $400 per calendar year	
Hardware for members under age 19 *Frames, lenses and contact lenses*	One pair of frames and lenses per calendar year or 12 month supply of contacts.	
***Member may be balance billed for claims exceeding allowable amounts.**		

Note This benefit is included in the Premera Blue Cross medical plan benefits. Same limits apply to both plans. This benefit outline is for illustrative purposes only. Actual claims paid are subject to the terms and conditions of the contract.

DENTAL BENEFITS

Administered by Premera Blue Cross

Oral care is very important to your health and general wellbeing. Parametrix provides comprehensive dental coverage through Premera Blue Cross. Each enrolled member receives the benefits illustrated below.

You may seek care from a participating dentist or any licensed dentist; however, if you use a Premera Blue Cross participating dentist, there are no claim forms necessary and dentists cannot charge you for any charges above usual, customary and reasonable (UCR) charges. The website is www.Premera.com.

CALENDAR YEAR = JAN 1 - DEC 31	ANY LICENSED PROVIDER
CALENDAR YEAR DEDUCTIBLE	
Per person	$25
Family maximum	$75
CALENDAR YEAR BENEFIT MAXIMUM	
Per person	$2,000
LIFETIME ORTHODONTIA MAXIMUM BENEFIT	
Per person	$2,500
MEMBER WILL PAY AS FOLLOWS:	
Diagnostic and Preventive Services Exams, cleanings, x-rays, fluoride treatment,	Covered in full (Deductible waived)
Routine Care Fillings, extractions, oral surgery, periodontics, endodontics	20%
Major Services Crowns, bridges, dentures, inlays, onlays, implants	50%
Orthodontia (Adult and Child)	50% (Deductible waived)
Predetermination Limit: If a treatment plan involves expenses of more than $300, the plan should be submitted to Premera Blue Cross for	

Note: This benefit can be elected independently of the Premera Blue Cross medical benefits. It is available even if you waive medical coverage.

Note This benefit outline is for illustrative purposes only. Actual claims paid are subject to the terms and conditions of the contract.

Preventive Incentive

Preventive care services do not accrue towards the annual dental benefit maximum, making the $2,000 benefit go further!

Usual, Customary and Reasonable Charges (UCR)

All charges are subject to the UCR allowance set by Premera Blue Cross. Meaning, Premera Blue Cross will pay providers for their services based on averages within any given zip code. For a claim to be processed, you must seek care from a licensed dentist. However, if your dentist charges more than the UCR amount, you will be responsible for the difference between the two (this is also known as “balance billing”).

PREMERA | BLUE CROSS

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Navia Benefit Solutions

Due to IRS Regulations, if you are enrolling in the High Deductible Health Plan (HDHP), you are not eligible to participate in the Healthcare Flexible Spending Account.

A Flexible Spending Account (FSA) program enables you to set aside money on a pre-tax basis to pay for health and daycare costs. An FSA is the only benefit that actually saves you money on the cost of health and daycare expenses. On average you can save anywhere from 25%-40%!

You must complete a new enrollment form each plan year to continue to take advantage of the tax savings offered by this plan. Elections will be made via the ADP portal.

How The Flexible Spending Account (FSA) Works

- You can choose to pledge up to **$3,300** before taxes into your Healthcare Account. This pre-tax money can be used to pay for qualified healthcare expenses not covered by your medical plan.
- You can also choose to pledge up to **$5,000** before taxes into your Dependent Care Account. (If you are married and filing separately, your limit is $2,500.) This pre-tax money can be used to pay for qualified daycare expenses for your children or disabled spouse.
- The total amount you choose to pledge into these accounts will be deducted out of your paycheck pre-tax in even portions over 12 months, starting January 1st. You receive 26 regular paychecks. However, the pledged amount is deducted from only 24 paychecks.
- Once you have chosen the amounts you want to pledge into these accounts, you cannot change them until the next open enrollment. An exception can be made if you have a major change in status, such as getting married or divorced, or having a baby.
- Please note: pledged amounts cannot be transferred between accounts. For example, you cannot use your Dependent Care Account to reimburse yourself for healthcare expenses and vice versa.

navia benefit solutions

Use-it-or-lose it?

If you have between $60 and $660 remaining in the Healthcare FSA at the end of the 2025 plan year, that balance will carry over automatically to the next Healthcare FSA year. Anything below $60 will not carryover unless you have re-enrolled to make your election $60 or higher.

This carry over feature only applies on the Healthcare FSA. You are not eligible for the $660 carry over if enrolling in the HDHP for the following year.

All funds remaining in your Dependent Care FSA at the end of the plan year, and any balances above $660 in your Healthcare FSA, will be forfeited. You must use the 2024 Healthcare FSA rollover amounts by December 31, 2025.

You have 90 days after the plan year to submit for reimbursement of claims incurred prior to December 31 of the plan year.

HOW TO PAY FOR EXPENSES & GET REIMBURSED

Debit Card

- You can use your FSA Debit Card to pay for healthcare expenses. (You cannot pay for daycare expenses with this card.)
- When using the FSA Debit Card, keep the receipt for your expense in a safe place. You may receive an e-mail or letter asking you to send in the receipt to support your claim.
- Send in the receipt and a copy of the letter as requested. If you do not send the receipt or if you used the card to pay for an expense that is not qualified, you will be asked to pay back the amount of the expense you put on the card.
- FSA debit cards will be automatically issued to you if an e-mail address is provided on the FSA election form. If an e-mail address was not provided, you can request a form from Navia. You may also elect a card for your spouse and dependents. Just login to www.NaviaBenefits.com or contact customer services.

Pay up front

- If you do not use the FSA Debit Card, fill out a claim form (available online under 'Insurance Forms' at https://c2mb.ajg.com/parametrix/ and mail or fax it along with the receipt to Navia Benefit Solutions. For online claims, provide Navia with the date of service, type or service, and how much your responsibility is. A claim form will be needed if the information is faxed or sent by email.
- Download the free MyNavia smartphone app. Have access to real-time account balances, tutorial videos, account alerts, and claim submissions. Simply search "MyNavia" on Google Play or Apple Store.
- You will typically receive your refund within 5-7 business days. Navia Benefit Solutions also offers a Direct Deposit reimbursement option (see enrollment form for details).

Examples of Qualified Healthcare Expenses:

- Copays for doctor visits and prescriptions drugs
- Coinsurance for your medical, dental, and vision plans
- Deductible amounts for your medical, dental, and vision plans

How Can I Manage My Accounts Online?

- To learn more about FSA plans or to manage your accounts, go to www.NaviaBenefits.com. You will need to complete a one-time registration.
- The employer code needed for registration is "**PMX**".

navia benefit solutions

WHICH MEDICAL PLAN IS RIGHT FOR YOU?

How the Plans Work

Both plans use the Premera Blue Cross Heritage Plus network and cover 100% of the cost for preventive care services such as annual physicals and routine immunizations. However, the way you pay for care is different with each plan.

With the **HDHP**, you pay the full negotiated cost for medical services and prescription drugs until you meet your calendar year deductible. Once you meet the deductible, you and the plan share the costs (coinsurance) until you reach the calendar year out-of-pocket maximum. After that, the plan pays for 100% of your in-network claims for the rest of the year. Your payroll deductions for this plan are lower than the PPO plan.

The **PPO plan** has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum. This plan has a higher payroll deduction amount than the HDHP.

	PPO PLAN	HDHP PLAN
Per-paycheck Cost for Coverage	$48 (employee only)	$0 (employee only)
Annual Deductible	$1,500/$3,000	$2,000/$4,000 aggregate
Annual Out-of-Pocket Maximum	$8,000/$16,000 (In-network)	$5,000/$10,000 (in-network)
Using the Plan	Pay more with each paycheck and less when you need care	Pay less with each paycheck and more when you need care
Spending Account Options	Healthcare FSA Dependent care FSA	Health savings account (HSA) Partially funded by Parametrix Dependent care FSA

Paying For Healthcare

Parametrix offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The healthcare accounts available to you depend on the medical plan you choose.

	HEALTHCARE FSA	HSA
What medical plan can I choose?	PPO Plan	HDHP
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)
When can I use the funds?	All of the funds you elect for the year are available on January 1	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, you can rollover between $60 to $660 of your funds to the next year	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)
How do I pay for eligible expenses?	With your Navia Benefits debit card (You can also submit claims for reimbursement online at www.NaviaBenefits.com)	With your HSA Bank debit card (You can also submit claims for reimbursement via mobile application)
How much does Parametrix contribute each year?	Parametrix does not contribute to an FSA	Parametrix contributes $1,250 for employee only coverages or $2,500 for employee/family
How much can I contribute each year?	You can contribute up to $3,300 to your Healthcare FSA in 2025	You can contribute $4,300 for individual coverage or $8,550 for family coverage (this total includes company funding) in 2025
Can I change my contributions throughout the year?	No, unless you have a qualifying life event	Yes, you can log on to change your HSA contributions on a monthly basis

COMPARING THE PLANS

When deciding which medical plan is the best fit for you and your family, it's important to consider the total cost of coverage. While each medical plan covers preventive screenings in full, the medical plans vary on annual deductibles, copays, and levels of coinsurance. In addition, it is important to factor in the HSA contributions from Parametrix when considering the HDHP.

To help you decide which health plan is best for your needs, think about whether you are a low, moderate, or high healthcare user, and review the corresponding situations below.

Disclaimer: Based on your actual circumstances, the HDHP Plan may not be the most appropriate plan for your medical plan needs.

Low Healthcare User #1

Erik is health-focused and is diligent in obtaining his annual preventive care check-up. During the year, he sprains his ankle, requiring a visit with x-rays, and later contracted strep throat, requiring a primary visit and a generic antibiotic prescription. He also has $200 in out-of-pocket costs for daily contacts.

	PPO PLAN	HDHP PLAN
Total covered expenses $400 preventive care, $150 office visit x 2, $200	$920	$920
Health plan covers	$820	$400
Erik's share of medical expenses*	**$100**	**$520**
Vision expenses	**$200**	**$200**
Erik's total expenses	$300	$720
Erik's portion of medical premiums (Employee only)	$1,152	$0
Parametrix annual HSA contribution	$0	$1,250
Erik's out-of-pocket cost for this year	**$1,452**	**$0**
HSA rollover to next year	**$0**	**$530**

**Erik's share explanation: Preventive care covered in full on both plans.*

- **HDHP**: Deductible not met, no coinsurance; Erik responsible for all $520.
- **PPO**: $25 copays x 2 for office visits; $40 for x-rays (20% coinsurance); $10 Generic prescription copay.

Low Healthcare User #2

Amy is on her second year of HDHP/HSA enrollment and receives $1,250 from Parametrix deposited in her HSA. She still has $750 from last year's HSA funds that rolled-over. During the year, she loses a close friend, visits a counselor a few times under the medical plan, also used three free visits with the EAP, and is prescribed a generic antidepressant for six months. In addition to the counseling, she visits a chiropractor monthly.

	PPO PLAN	HDHP PLAN
Total covered expenses ($175 office visit x 2, $40 chiropractic visits x 12, $4 generic prescription x 6)	$854	$854
Health plan covers	$374	$0
Amy's share of medical expenses*	**$480**	**$854**
Amy's share of EAP expenses	**$0**	**$0**
Parametrix annual HSA contribution	$0	$1,250+$750 (from prior year)
Amy's portion of medical premiums (Employee Only)	$1,152	$0
Amount paid from HSA* (Amy's choice)	$0	$854
Amy's net out-of-pocket cost this year	**$1,632**	**$0**
HSA rollover to next year	**$0**	**$1,146**

**Amy's share explanation: EAP resources are no cost for 3 visits per year.*

- **HDHP**: Deductible not met, no coinsurance; Amy is responsible for all $854.
- **PPO**: $25 copays x 2 for office visits; $25 x 12 for chiropractic visits, $4 per script x 6.

Moderate Healthcare User #1

Benjamin and Teresa are newly married and do not currently have any HSA savings. Benjamin and Teresa recently found out that they are going to be parents in the upcoming year.

	PPO PLAN	HDHP PLAN
Total covered expenses (pregnancy bundle + newborn expenses)	$23,000	$23,000
Health plan covers	$16,700	$17,900
Teresa's share of medical expenses*	**$5,800**	**$5,000 (Teresa met OOPM)**
New baby share of medical expenses*	**$500**	**$100**
Parametrix annual HSA contribution	$0	$2,500
Teresa's portion of medical premiums	$10,488	$5,424
Amount paid from HSA* (Ben/Teresa's choice)	$0	$2,500
Ben/Teresa's net out-of-pocket cost this year	**$16,788**	**$8,024**
HSA rollover to next year	**$0**	**$0**

**Ben and Teresa's share explanation:*

- **HDHP**: Family Aggregate Deductible met, 20% coinsurance until out of pocket max is met for Teresa. Baby's deductible was paid under aggregate deductible, but still has separate out-of-pocket maximum. Assumes coinsurance on $500 of medical bills for baby.
- **PPO**: Teresa pays deductible / coinsurance up to out-of-pocket maximum. Baby's services accrue to his/her own deductible.

Moderate Healthcare User#2

Kristine is on a non-preferred brand name drug which helps her manage a chronic condition. The drug itself costs $2,000 each fill.

	PPO PLAN	HDHP PLAN
Total covered expenses ($24,000 Rx)	$24,000	$24,000
Health plan covers	$23,400	$19,000
Kristine's share of medical expenses*	**$600**	**$5,000**
Parametrix annual HSA contribution	$0	$1,250
Kristine's portion of medical premiums (Employee Only)	$1,152	$0
Amount paid from HSA* (Kristine's choice)	$0	$1,250
Kristine's net out-of-pocket cost this year	**$1,752**	**$3,750**
HSA rollover to next year	**$0**	**$0**

**Kristine's share explanation:*

- **HDHP**: Deductible met, 20% coinsurance until out of pocket max is met. Kristine was able to use HSA dollars towards her expenses. She also could have saved her HSA dollars for a later time.
- **PPO**: Deductible waived, $50 copay x 12 for non-preferred brand name drugs.

High Healthcare User #1

The Craig family of four is enrolled in the Parametrix PPO medical plan and has ongoing healthcare needs. Son Elroy has a chronic condition that requires monthly visits to the doctor, several maintenance Rx drugs and he was hospitalized during the year. Nobody else in the family had any expenses other than preventive care.

	PPO PLAN	HDHP PLAN
Total covered expenses ($35,000 hospitalization, $175 office visit x 12, 20 Rx at $100 per fill and $400 preventive care x 3)	$40,300	$40,300
Health plan covers	$32,300	$35,300
Craigs' share of medical expenses*	**$8,000 (met per person OOPM)**	**$5,000 (met per person OOPM)**
Parametrix annual HSA contribution	$0	$2,500
Craigs' portion of medical premiums (Family)	$10,488	$5,424
Amount paid from HSA* (family's choice)	$0	$2,500
Craigs' net out-of-pocket cost this year	**$18,488**	**$7,924**
HSA rollover to next year	**$0**	**$0**

**The Craigs' share explanation: Preventive care covered in full on both plans.*

- **HDHP**: For Elroy, the family aggregate deductible met, 20% coinsurance until out of pocket max is met for him.
- **PPO**: Hospital services apply to deductible and coinsurance. Elroy's parents pay his deductible and then pay 20% of billed hospital services. The deductible, coinsurance, office visit copays, and the prescription drugs all count towards the out-of-pocket maximum.

High Healthcare User #2

The Wilson family of four doesn't currently have any HSA savings and has ongoing healthcare needs. Daughter Alaina has a chronic condition that requires monthly visits to the doctor, several maintenance medications, and was hospitalized during the year. Wife Jane had several broken bones and required surgery after a bike accident. Husband George had to have his knee replaced.

	PPO PLAN	HDHP PLAN
Total covered expenses ($35,000 hospitalization, $175 office visit x 12, $5,000 ER visit and x-rays, 20 Rx drugs at $100 per, $1,000 for physical therapy, $22,000 knee replacement bundle)	$67,100	$67,100
Health plan covers	$51,100	$57,100
Wilsons' share of medical expenses*	**$16,000 (met family OOPM)**	**$10,000 (met family OOPM)**
Parametrix annual HSA contribution	$0	$2,500
Wilsons' portion of medical premiums (Family)	$10,488	$5,424
Amount paid from HSA* (Wilsons' choice)	$0	$2,500
Wilsons' net out-of-pocket cost this year	**$26,488**	**$12,924**
HSA rollover to next year	**$0**	**$0**

**The Wilsons' share explanation:*

- HDHP: For the Wilsons, the family aggregate deductible is met, 20% coinsurance until out of pocket max is met. In this case with so many family members needing services, the family out-of-pocket is met and all services past $10,000 from an in-network provider are covered by the plan during the calendar year.
- PPO: Hospital services apply to deductible and coinsurance. After each family member pays their deductible, they then pay 20% of billed hospital services up to the out of pocket maximum. On this plan, two family members met the maximum and now the maximum is met for the entire family.

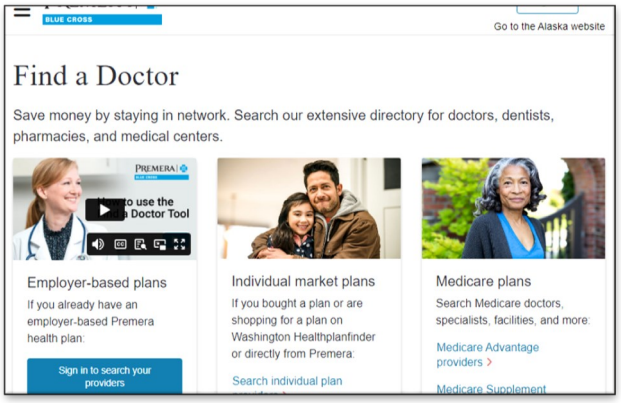
PREMERA RESOURCES

Premera Online Tools

You can access your medical and dental claims information 24/7 in a secure environment through the Premera Blue Cross member portal. Log into your member account at www.Premera.com and you can research claims, print EOBs and view documents related to your benefits plan.

To set up your member portal/account, follow the following steps:

- Step 1: Visit www.Premera.com
- Step 2: On the top right hand corner, click on “Log In” and select “Create Member Account” from the drop-down menu
- Step 3: Enter your name and e-mail address
- Step 4: Create your user ID and password
- Step 5: Set up your security questions
- Step 6: Click on “Complete your registration”
- Step 7: Login with your username and password
- Step 8: Enter your plan information (You will need your SSN or Premera member ID#, birthdate and zip code)
- Step 9: Click on “Complete Registration”

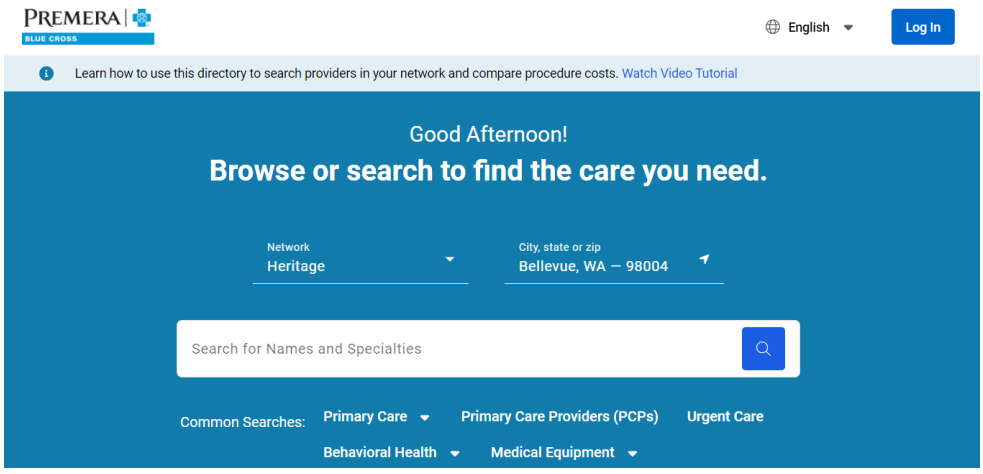


Search for Doctors and Hospitals with Premera’s Healthcare Provider Directory.

- Find doctors and facilities within the Premera network to receive the highest possible benefit coverage that your plan offers
- Find doctors who have experience with a specific health issue
- Find doctors by specialty (Allergy & Immunology, Family Medicine, and more)
- Find doctors who are affiliated with a specific hospital
- Save your favorite healthcare providers in "My List" for easy reference

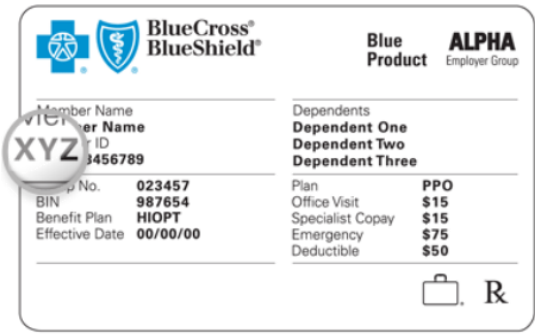
Please follow these easy steps to find a provider in WA or AK:

- Step 1: Visit www.Premera.com and click “Find a Doctor”
- Step 2: Click “Browse all doctors and specialists”
- Step 3: Select the *Heritage network*
- Step 4: Search by name of the doctor, hospital or pharmacy name or by specialty or health needs. Enter your starting location (Within __ miles of ZIP) or by entering a Street Address or City and State and click Go.
- Step 5: Narrow your results by the drop down menus provided; options include Male or Female, Accepting New Patients, Language, Board Certified, and/or Specialties.

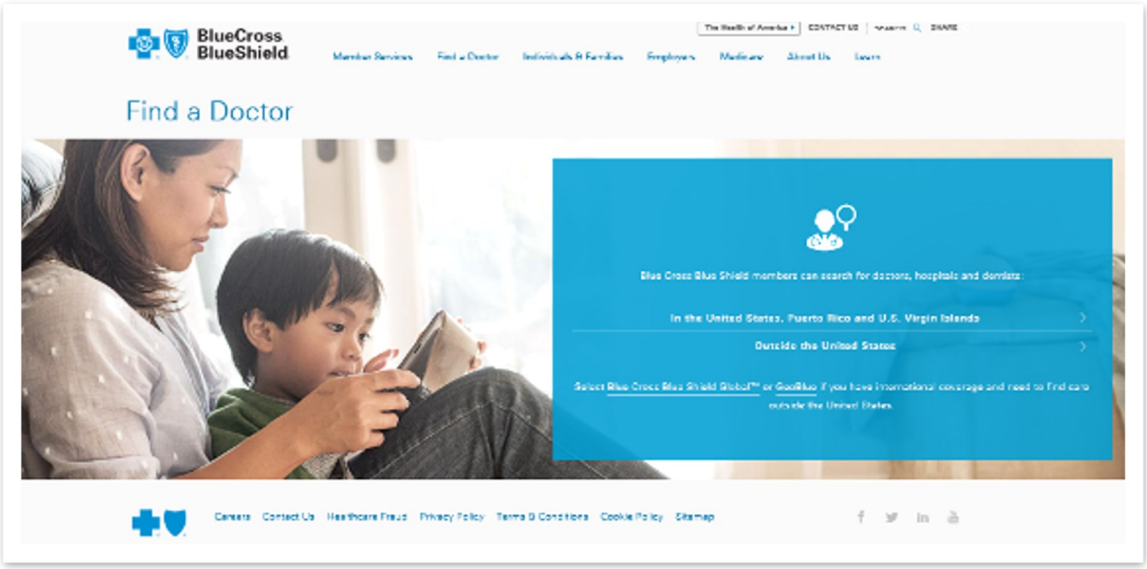


Please follow these easy steps to find a provider when traveling outside/living outside of WA or AK

- Step 1: Visit www.BCBS.com
- Step 2: Click on “Find a Doctor”
- Step 3: Click on “In the United States, Puerto Rico and U.S. Virgin Islands”
- Step 4: Enter your location and enter the first three letters or numbers of your member ID; or click on “Select Plan” and select BlueCard PPO/EPO
- Step 6: Enter your search criteria for the provider/facility you need



You may also contact the BlueCard® Program representatives for assistance by calling 800.810.2583. The center is open 24 hours a day, seven days a week



Please follow these easy steps to find a provider when traveling outside of the United States

- Step 1: Visit www.BCBSGlobalCore.com
- Step 2: Review the Terms of Use and End User License Agreement and (if you agree) click on “I accept the terms and conditions described above.”
- Step 3: Enter the first three letters or numbers of your Member ID number
- Step 4: Follow the steps to register for access to the site and follow the steps to find providers in your international location

The BlueCross BlueShield Global Core Service Center is accessible 24 hours a day via phone at 800.810.2583 or collect at 804.673.1177. A representative can help you find providers in international area and determine if direct billing can be arranged between the international provider and your Plan.

VIRTUAL CARE WITH PREMERA

Premera has a virtual health network providing easy access to board certified, quality care that saves you money and time. Once enrolled, register at Premera.com to learn more about the virtual care resources available to you and your enrolled family members.

Download the Premera MyCare app to find options available to you in one mobile application!

Doctor On Demand Primary and Behavioral Healthcare

https://www.doctorondemand.com/premera **Availability:** 24/7 Access or by appointment

What it is: A video or phone-based consultation with a board-certified doctor or licensed psychologist. It's easiest to set up your account by downloading the Doctor on Demand mobile app, so it's ready before you need care. You can also reach Doctor on Demand on the web: www.doctorondemand.com/premera.

What it's for: Diagnosing and treating common illnesses, such as sinus problems, urinary tract infection, pink eye, bronchitis, upper respiratory infection, nasal congestion, allergies, flu, skin infections and rash as well as behavioral health visits. They can even prescribe certain drugs if necessary.

98point6 Text-Based Virtual Care

https://www.98point6.com/premera **Availability**: 24/7 Access

What it is: 98point6 is a new kind of on-demand primary care delivered through a highly secure in-app messaging experience on your mobile phone. With 98point6, U.S-based, board-certified physicians answer questions, diagnose and treat acute and chronic illnesses, outline care options and order any necessary prescriptions or lab tests. 98point6 can also help you better understand any primary care conditions.

Boulder Treatment for Substance Abuse Disorder

start.boulder.care/ **Availability:** 24/7 Access

What it is: Boulder Care provides treatment for opioid use disorder and alcohol use disorder. With this program, members can have video visits and text messaging with a therapist.

Talkspace Virtual Therapy for Behavioral Health

talkspace.com/premera **Availability**: 24/7 Access

What it is: easily connect to therapists and psychiatrists by video and text. Start by signing up at talkspace.com/premera using Chrome, Firefox, Safari or Edge, get matched with the best therapist for you and start messaging your therapist right away. You can also visit the Premera behavioral health digital resource center at www.premera.com/visitor/mentalhealth to find useful resources, information on starting conversations, and more.

Omada – Virtual Physical Therapy Provider

https://go.omadahealth.com/premera

What it is: Omada is a virtual physical therapy provider that is accessed by the member through a mobile app. With Omada, you will receive an individualized care plan built around your schedule with continuous support from a physical therapist. During an initial video consultation, members will be evaluated if the Omada recovery program is appropriate for their care. Members will be sent the equipment needed to complete their treatment program.

PREMERA NURSELINE

Because we understand that sometimes your healthcare needs don't have a schedule, we offer you peace of mind with round-the-clock access to the Premera Blue Cross 24-hour NurseLine. The NurseLine is staffed by registered nurses who are trained to offer advice, guidance and support to you and your family.

Treatment Recommendations:

NurseLine nurses are trained to ask the right questions to make a recommendation about when and where you should seek treatment for an injury or illness. Nurses base their recommendation on your symptoms and other relevant health conditions or history. If you need immediate care, nurses can direct you to the closest urgent care center or Emergency room in your area.

Free and Confidential:

All calls to the NurseLine are free and always remain confidential so you can talk as much and as openly as needed about the health conditions that concern you.

Honest Information and Open Conversation:

NurseLine nurses have access to high-quality health resources and will listen to your concerns, answer questions and offer advice about many health-related topics.

Note: *Healthcare advice from the knowledgeable NurseLine nurses can help you understand and better manage your health conditions, as well as provide peace of mind about what to expect from a health condition. Nurses are accessible by phone 24-hours a day, seven days a week at* ***800.841.8343****. This phone number is also listed on the back of your Premera Blue Cross member ID card.*

24/7 NurseLine:
800.841.8343

LEGAL NOTICES

Important Information Regarding your Medical Benefit Plan

Non-Network Costs

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

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

Out-of-Area Benefits

If you are traveling or living outside of Washington and need medical care, you may use a Blue Cross or BlueShield PPO provider to receive the same benefits as the preferred level of your plan. When you are outside of the service area and need medical care, call the BlueCard Access Line at 800.810.BLUE (2583) for information on the nearest PPO doctors and hospitals. The doctor or hospital will verify your membership and coverage information after you present your identification/membership card. The doctor or hospital will electronically route your claim to your Blue Cross plan for processing. Because all PPO providers are paid by the plan directly, you are not required to pay for the care at time of service and then wait for reimbursement. You will only need to pay for out-of-pocket expenses, such as non-covered services, deductible, copays and coinsurance.

HIPAA 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 your-self and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage un-der Medicaid or your state Children's Health Insurance Pro-gram, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 30 days after that coverage ends or after you become eligible for premium assistance.

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

Preventive Care

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

Summary Plan Descriptions

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we've tried to summarize the provisions of these legal documents clearly and accurately, if any information presented here conflicts with the legal documents, the legal documents will govern

For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents.

All benefit plans are subject to change from time to time and Parametrix reserves the right to amend or cancel any benefits described in this booklet, with or without notice. This document does not guarantee any benefits.

Networks

No matter where you live or seek care, Premera has in-network providers available so you can keep your out-of-pocket expenses as low as possible. Both of our plans are PPO (Preferred Provider Organization) plans and offer a wide choice of providers. You may seek care from any licensed provider, however, when you seek care from an in-network PPO provider, your cost share will be less.

COBRA

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by TELUS

Parametrix provides an Employee Assistance Program (EAP) through TELUS (formerly LifeWorks). The EAP offers free and confidential counseling and assistance in resolving situations that may impact your personal or professional life. All Parametrix employees and their eligible family members are automatically covered by the EAP, and Parametrix pays the entire cost of this coverage. The EAP provides short term counseling and referrals to help you deal with a variety of issues that can affect you at work or at home, such as:

- Parenting and child care
- Education
- Older Adults
- Midlife and retirement
- Disability
- Financial
- Legal
- Everyday issues
- International issues
- Work and career
- Managing people
- Health
- Emotional wellbeing
- Addiction and recovery

http://login.LifeWorks.com
Username: *paraeap*
Password: *parametrix*
Toll Free: 877.259.3785

Every year of your life brings new changes, some big, some small. If you could use advice, information, or just a little encouragement to get you through tough times or help make good times even better, the TELUS program is here to help. Whether you're expecting a new baby, struggling with credit card debt, caring for older relatives, or trying to cope with a family problem or personal issue, TELUS offers caring, professional consultants you can talk to 24/7. TELUS has an award-winning website where you can watch short videos, read articles, order free materials and resources, and much more. TELUS is brought to you and your family by Parametrix at no cost to you and it's completely confidential.

Following your initial call, you may receive coaching over the telephone with an EAP professional, or you may be referred to an appropriate counselor in your area, depending on your situation and your preference. If you visit a counselor, up to 6 sessions per situation are provided at no charge to you. If more sessions are needed, the EAP professionals can work with your health plan to determine further coverage.

How can an EAP help me?

Life is full of challenges, both large and small. Some issues are easy to handle...others may require more than you can balance on any given day.

- Stress on the job?
- Need financial guidance?
- Buying a new home?
- Substance abuse?
- Need a daycare provider?
- Experiencing family issues?
- Need a will?

Did you know? EAP services are 100% confidential and no personal information is reported back to Parametrix.

BEHAVIORAL HEALTH SUPPORT

Administered by UNUM

Personalized Support Programs

An intuitive navigator will match you with the support pathway that's right for you:

- 8-week Coaching: Your certified coach will meet with you virtually and provide personalized, chat-based guidance every step of the way. Reduce stress, build resilience, and deepen emotional intelligence through live workshops, digital content, and self-reflection prompts.
- 12-week Treatment: This convenient app-based program combines self-paced activities, face-to-face video sessions, and unlimited chat support from a licensed therapist to help you make lasting change in just 12 weeks.

Download the Unum Behavioral Health app to get started.

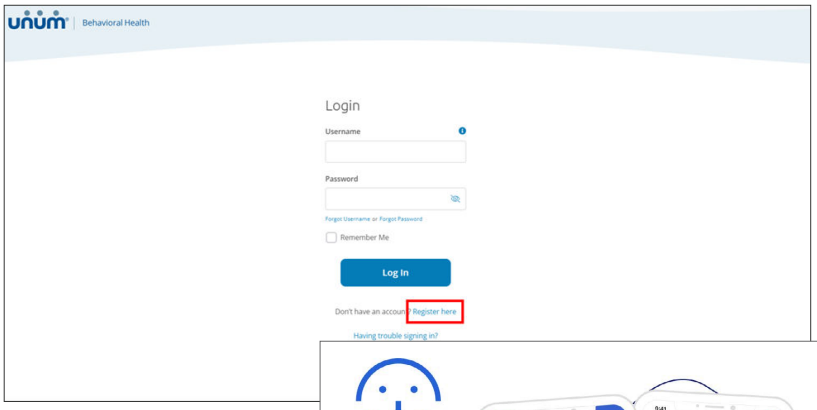
- Self-Paced Programs: Choose from a range of thoughtfully designed courses that allow you to move at your own pace. Identify symptoms and triggers, set goals, and develop new skills to manage stress, build resilience, and grow toward thriving.
- Guided Self-Therapy: With practical exercises, guided journaling, progress tracking, and conversation-driven support, this program customizes your plan to help you address concerns like anxiety or low mood.

Personal Reflection Activities

Private space on the mental wellness hub to help you track mood and energy, practice self-reflection throughout your journey, monitor progress, and view improvement over time.

Resource Library

Articles, videos, meditation, and more, selected for your interests and needs. Develop the confidence and skills to better support yourself and others as you explore topics like self-care, whole life balance, resilience, and mindfulness. Visit the Parent Hub to explore concerns and find resources to support the mental well-being of children.



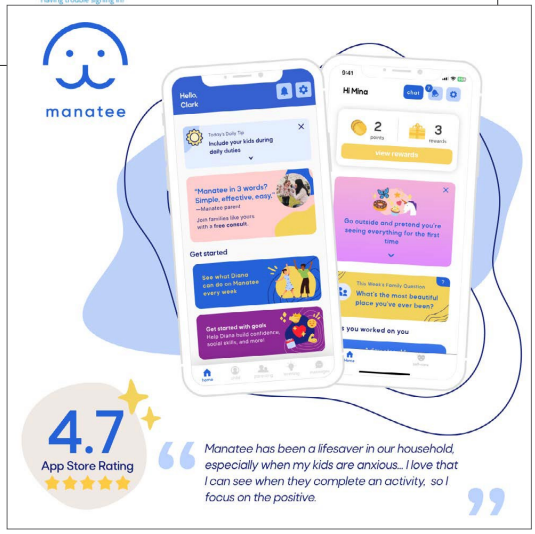
Follow these steps to get started with UNUM Behavioral

- Create your account by visiting https://behavioralhealth.unum.com and clicking "Register here" just beneath the login button.
- You will be prompted to enter your date of birth and SSN to identify your record. If you have an account on any other Unum platform, you may be able to use the same username and password.
- Watch the Get Started video and Complete the Support Navigator

Manatee

Through Unum Behavioral Health, Parent Hub & Manatee App-based mental health support for parents, children ages 8-12, and adolescents ages 13-18. Set weekly family goals and celebrate progress together. Includes:

- The Parent App: Support your kids with evidence-based tools, lessons, scripts, and daily tips
- The Child/Adolescent App: 24/7 access to evidence based tools, journal, self-care, and a friendly chatbot; track progress toward goals, and redeem fun family awards



LIFE AND DISABILITY BENEFITS

Administered by UNUM

Life insurance provides financial security for the people who depend on you. Disability insurance helps protect your income if you become ill or injured and are unable to work. Parametrix provides all eligible employees with Basic Life, Accidental Death and Dismemberment (AD&D), Short-Term and Long-Term Disability Insurance benefits through UNUM as outlined below:

Basic Life Insurance

In the event of your death, this plan pays your beneficiaries a benefit of one times your annual base earnings to a maximum $100,000. This benefit reduces 35% when you reach age 70 and 50% when you reach age 75.

Accidental Death and Dismemberment (AD&D)

In the event of your accidental death, this plan pays your beneficiary a benefit of one times your annual base earnings to a maximum $100,000. If you are seriously injured as the result of an accident (e.g., lose your eyesight), this plan will pay a partial benefit to you. This benefit reduces 35% when you reach age 70 and 50% when you reach age 75.

Disability insurance

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset—your ability to earn an income. Benefits may offset by other sources of income.

Short-Term Disability (STD)

STD coverage provides income if you are unable to work for a limited period of time due to an illness or injury that is not work-related. The STD benefit begins on the 8th day you have been out of work due to an illness or injury. Your benefit is 60% of your earnings, up to $1,800 per week. Benefits may continue up to 12 weeks. Your short term disability benefits may be reduced (or offset) when other state disability or leave programs are available.

NOTE: The normal duration for a pregnancy claim is six weeks. Therefore, after the 7-day elimination period, benefits will typically be payable for five weeks for a normal maternity claim assuming the date of disability is the delivery date.

Long-Term Disability (LTD)

LTD coverage provides income when you have been disabled for 90 days or more. Your benefit is 60% of your base earnings, up to $13,000 per month. This amount may be reduced by other deductible sources of income or disability earnings. Benefit payments may continue up to Social Security Normal Retirement Age (Reducing Benefit Schedule). For your specific benefit information, please contact your Benefit Advocate at Gallagher Benefit Services or your Human Resources Business Partner.

WELLNESS PROGRAM

Benefits offered through ADURO

Parametrix has teamed up with ADURO, a third-party wellness company, to provide a dynamic personalized web-based health and wellness program for Parametrix employees. The program encompasses the health of the whole individual – mind, body, and soul.

Within our wellness program (January 2, 2025 through December 31, 2025) employees are able to participate in wellbeing challenges, track personal goals, find resources, and receive unlimited complimentary health coaching. Participants can take a wellbeing self-assessment and submit a provider biometric screening form—the confidential results of both are combined to provide personalized health recommendations.

There are great long-term benefits to every step taken with this program. Healthy employees are stronger, have more energy, and are better able to manage the daily stresses of life. It is difficult to calculate the dollar for dollar return on investment, but the health of our employees is invaluable.

While participation is completely confidential and voluntary, the wellness program has been designed with you in mind and provides easy access to high-quality resources for improving health and wellbeing.

Participants are able to:

- Complete a wellbeing self-assessment
- Learn your greatest healthy strengths
- Create your own tailor-made wellness plan
- Participate in challenges to earn points and win prizes
- And more!

imagine well-being

The more you participate the more points you earn towards reaching new levels and new incentives. Be assured that personal information is secure and confidential and rewards are based on participation—not specific measures. To join the wellness program go to https://parametrix.adurolife.com/ and activate an account. New employees will receive a formal invitation to participate.

Questions about the wellness program may be directed to BeWell@parametrix.com.

Incentive Prizes Include:

Level 1: Inspired - 1,000 points = $100.00 cash

Level 2: Motivated - 2,000 Points = $250.00 cash

Level 3: Empowered - 3,000 Points = $500.00 cash

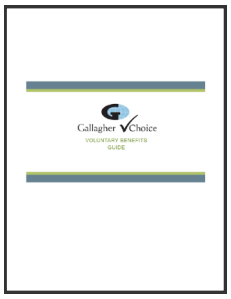
VOLUNTARY INSURANCE BENEFITS

Administered by Gallagher vChoice

Voluntary Insurance Benefits—Gallagher vChoice

Since everyone's insurance needs are different, Parametrix gives you the option to buy additional insurance for yourself and your family members on a voluntary basis, but at discounted group rates through Gallagher vChoice. You may purchase the following voluntary plans when initially benefit eligible or during open enrollment. Premiums will be paid through payroll deduction. Please refer to your Gallagher vChoice Employee Guide for additional benefit information.

- Employee, Spouse/Domestic Partner and Child/ren Term Life Insurance
- Long-Term Care Insurance for employees, as well as your spouse or domestic partner, adult children, adult siblings, in-laws, parents and grandparents.
- Accidental Death & Dismemberment



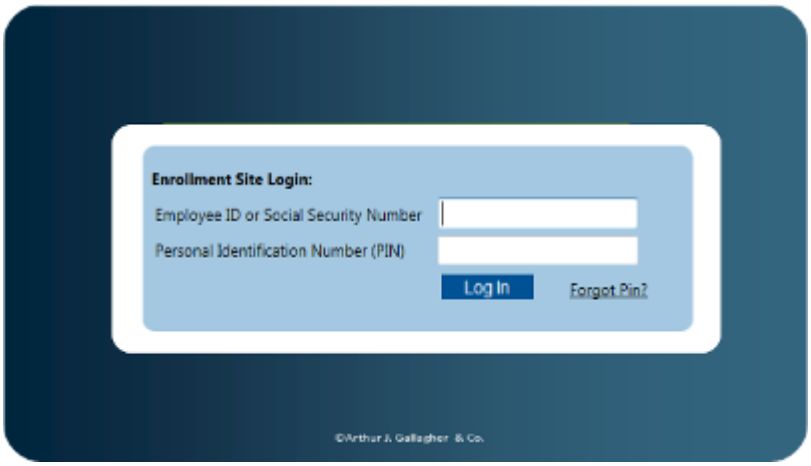
How to enroll in voluntary benefits:

Enrolling Online

You may enroll in Gallagher vChoice through the enrollment website. Premiums have already been calculated on your behalf. Please note that the premiums shown on the site are monthly premiums. You will have your premiums deducted in even payroll amounts each month.

Enrollment Site: GallaghervChoiceEnroll.com

PIN: *The last four digits of your Social Security Number followed by the two digit year of your birth*.
Ex: Someone born in 1980 and with a SSN of 123-45-6789 would have the PIN 678980.



Have Questions or Need Assistance?

Your Gallagher Benefit Advocate team is here to support you with questions on the voluntary benefits and the enrollment site.

Your team can be reached at 833.737.4720.

Most benefits require you to be actively-at-work for initial approval or for plan changes. Dependents who are currently disabled are not eligible to enroll in life insurance (or increase election numbers) until no longer disabled. For additional details, please refer to the Gallagher vChoice guide.

GALLAGHER MARKETPLACE

Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, pre-paid legal services, identity theft protection, pet insurance, renters insurance, boat or RV insurance, employee discount perks as well as extended vehicle warranties.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what benefits your organization offers through Gallagher Marketplace.

The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

How It Works

1. Visit Gallagher Marketplace to see your available benefits.
2. Select a product to view more details.
3. Click on the partner link to learn more, get a free no obligation quote or apply for coverage.

To learn more, scan the QR code or visit c2mb.ajg.com/gmpc/benefits

LEGAL NOTICES

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance
Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

GEORGIA – Medicaid
GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

FLORIDA – Medicaid
Website:https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

LOUISIANA – 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)

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

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en US
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

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462 CHIP Phone: 1-800-986-KIDS (5437)
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health care/medicaid/
Phone: 1-800-541-2831

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/upp/
Email:upp@utah.gov Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select, https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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)

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notice of Creditable Coverage

Important Notice from Parametrix
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Parametrix 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. Parametrix has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join 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.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Parametrix coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Parametrix coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the Parametrix benefit plan during the open enrollment period under the Parametrix benefit plan.

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

You should also know that if you drop or lose your current coverage with Parametrix and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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:	January 1, 2025
Name of Entity/Sender:	Parametrix
Contact—Position/Office:	Leslie Sowles - Director of Human Resources
Office Address:	1019 39th Ave SE Ste 100 Puyallup, Washington 98374-2115 United States
Phone Number:	503.388.7478

HIPAA Notice of Privacy Practices

Protecting Your Health Information Privacy Rights

Parametrix is committed to the privacy of your health information. The administrators of the Parametrix Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Leslie Sowles - Director of Human Resources at 503.388.7478 or LSowles@parametrix.com.

Statement of ERISA Rights

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

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

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

You have rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan.

These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

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

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

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

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

PLAN ADMINISTRATOR

PARAMETRIX / ADDRESS: 1019 39TH AVE SE, SUITE 100, PUYALLUP, WASHINGTON 98374 / PHONE: 253.501.5194

Wellness Program Disclosure

The Parametrix wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for be specific about the conditions for which blood will be tested. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $850 for completing all the wellness activities and reaching the different prize levels. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the maximum prize amount, corresponding to level achieved.

Additional incentives may be available for employees who participate in certain health-related activities such as wellbeing challenges, health coaching or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Director of Human Resources at 503.388.7478.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and goal tracking. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Parametrix may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who may receive your personally identifiable health information is (are) a registered nurse or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 253.501.5194 or via e-mail at BeWell@parametrix.com.

YOUR BENEFIT CONTACTS

Benefit Advocate Center

Service provided by Gallagher Benefit Services

Answers your questions and provides help resolving issues pertaining to your health, life and disability benefits.

BAC.Parametrix@ajg.com
425.201.9144 or Toll Free: 833.737.4720
6:00 AM – 6:00 PM, M-F Pacific Time

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

BENEFIT	GROUP #	CARRIER	PHONE		WEBSITE/ADDRESS
Medical, Vision, & Dental	1037345	Premera Blue Cross	Customer Service Nurseline BlueCard® Access	800.722.1471 800.841.8343 800.810.2583	www.Premera.com www.BCBS.com **Mailing Address:** PO BOX 91059 Seattle, WA 98111-9159
Health Savings Account (HSA)	N/A	Optum Financial	Customer Service	800.941.6121	www.Premera.com
Employee Assistance Program	Parametrix	TELUS	24/7 Support	877.259.3785	http://login.LifeWorks.com Username: paraeap Password: parametrix
Behavioral Health Program		UNUM			behavioralhealth.unum.com
Life/AD&D, STD & LTD	218930	UNUM	Customer Service	800.421.0344	www.Unum.com
Flexible Spending Account (FSA)	PMX	Navia Benefit Solutions	Customer Service	800.669.3539 425.452.3500	www.NaviaBenefits.com claims@NaviaBenefits.com customerservice@NavaiBenefits.com
Gallagher Marketplace	N/A	Gallagher	Customer Service	N/A	www.ajg.com/us/gallagher-marketplace/
Voluntary AD&D Insurance	Varies by Participant	Gallagher vChoice (Voluntary Coverage)	Customer Service	833.737.4720	www.standard.com
Voluntary Life Insurance					www.unum.com
Voluntary Long-Term Care					

Benefits Website

https://c2mb.ajg.com/parametrix/

Gallagher

Insurance | Risk Management | Consulting

This overview has been prepared to briefly highlight key features of your plan and is not to replace your insurance contract or booklet. We have compiled information into summary form to answer questions we most commonly receive. Please refer to the insurance carriers' contracts and booklets for more detailed information and plan limitations. Actual claims paid are subject to the terms and conditions of the individual carriers' contracts.

2025

Benefits Guide

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