2027 Northwest Center Benefits Guide

January 1 – December 31



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A Message from Northwest Center

At Northwest Center we recognize our ultimate success depends on our talented and dedicated workforce. The contribution each employee makes is essential to our success and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Northwest Center Benefits Website

The Northwest Center website is your first stop for employee benefits information. Review eligibility, health plans, voluntary financial protection products and other important benefits all located at one website designed just for Northwest Center Employees.



Benefit Resource Center (BRC)

Have Questions, Need Help?

Northwest Center is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.



BRCWest@usi.com
Monday through Friday
8:00am to 5:00pm PT

(866) 468-7272

Eligibility

Eligible Employees:

You may enroll in the Northwest Center Employee Benefits Program if you are a full-time employee.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Members have 31 days after the date on which maximum age is attained to submit ongoing disability information. Children may include natural, legally adopted, stepchildren and children obtained through court-appointed legal guardianship.

Family Status Change:

A change in family status is an event in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make a request to the benefits administrator at Northwest Center within 60 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of family status within the required timeframe may result in your having to wait until the next open enrollment period to make your requested change. The change must be one that impacts eligibility and corresponds with the family member that is impacted.

Cost of Coverage

Northwest Center funds most of the cost of the medical, dental and vision plans. Deductions for our health plan will be made on a pre-tax basis unless you request otherwise. Pre-tax means that deductions are taken prior to calculation of your taxable income, thereby reducing your tax liability. *NWC has 26 pay periods per year but will take deductions out of 24 paychecks only.*

	Premera - Health Savings Plan		Premera - Traditional Plan	
	Monthly	**Per Pay Period**	**Monthly**	**Per Pay Period**
Employee	$33.00	$16.50	$165.00	$82.50
Employee + Spouse/DP*	$382.00	$191.00	$847.00	$423.50
Employee + Child(ren)	$148.00	$74.00	$487.00	$243.50
Employee + Spouse/DP + Child(ren)	$482.00	$241.00	$1,077.00	$538.50

	Delta Dental of WA - Dental Plan		Vision Service Plan (VSP) - Vision Plan	
	Monthly	**Per Pay Period**	**Monthly**	**Per Pay Period**
Employee	$25.00	$12.50	$8.00	$4.00
Employee + Spouse/DP	$46.00	$23.00	$13.00	$6.50
Employee + Child(ren)	$39.00	$19.50	$14.00	$7.00
Employee + Spouse/DP + Child(ren)	$78.00	$39.00	$21.00	$10.50

*DP = Domestic Partner

For domestic partners that do not qualify as dependents under Section 152 of the Internal Revenue Code, premium associated with domestic partner coverage will be paid by the employee with after-tax dollars and the fair market value of any employer contributions made on behalf of your domestic partner will be imputed as income to the employee. Unless otherwise requested, all other premiums will automatically be deducted on a pre-tax basis.

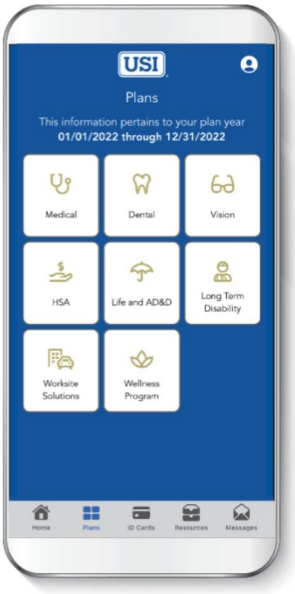
Important Contacts

Benefit	Carrier	Contact Information
Medical & Prescription Drug Plan Health Savings Account (HSA)	Premera Blue Cross Group #1037147	(800) 722-1471 www.premera.com Access your HSA through your www.premera.com/hsa account
Mail-Order Pharmacy Program	Express Scripts Group # 1037147	(800) 391-9701 www.express-scripts.com
Virtual Medical Care For Premera members only	Transcarent Talkspace	www.transcarent.com/ www.talkspace.com/premera
EAP Service	CuraLinc	(800) 553-7798 www.mysupportlinc.com
Virtual Mental Health For Premera members only	Spring Health	(855) 629-0554 www.springhealth.com
Dental Plan	Delta Dental of Washington Group # 00435	(800) 554-1907 www.deltadentalwa.com
Vision Plan	Vision Service Plan (VSP) Group # 12084243	(800) 877-7195 www.vsp.com
Flexible Spending Account (FSA) & Commuter Program	Navia Benefit Solutions Company Code: NCN	(800) 669-3539 www.naviabenefits.com
Life Insurance, Disability & Voluntary Plans	The Hartford Group # 925208	(860) 547-5000 www.thehartford.com

MyBenefits2GO Mobile App from USI

The MyBenefits2GO app gives you on-the-go access to Northwest Center's benefit and insurance policy details, HR contact information and more!

- **Staying Organized**
  Access benefit plan information and ID cards—all in one place.
- **Keeping Up-to-Date**
  The app automatically connects you with the most updated plan information.
- **Lightening Wallets**
  Store and share images of your ID cards in a secure setting.
- **Getting In Touch**
  Locate contact information for the Human Resources team, insurance carriers and the Benefit Resource Center.
- **Check Out the App**
  Download the mobile app to your smartphone. Enter the code **Y53986** to see your plan information.



Medical Insurance

Northwest Center offers you a choice of two medical plans with Premera Blue Cross, giving you the flexibility to select the plan that best fits your needs.

To help control the cost of your care, this plan uses Premera's Heritage network in Washington. When you see a preferred provider in the Heritage network, the amount you pay out of your pocket is lower than if you see an out-of-network provider. For care in Clark County and outside of Washington members can utilize contracted providers in the BlueCard program. Search for a BlueCard provider at www.bcbs.com.

	Health Savings Plan		Traditional Plan	
	In-Network Benefits	**Out-of-Network Benefits**	**In-Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductible*				
Individual	$2,000	$4,000	$600	$1,200
Family	$4,000 Shared***	$8,000 Shared***	$1,800	$3,600
Coinsurance	Plan Pays 80%	Plan Pays 60%	Plan Pays 80%	Plan Pays 60%
Calendar Year Maximum Out-of-Pocket (Made up of deductible, coinsurance and copay expenses)				
Individual	$4,000	$8,000	$3,000	$6,000
Family	$8,000	$16,000	$9,000	$18,000
Health Savings Account Calendar Year Contributions				
Employer Contribution	$1,000 Employee / $2,000 Family		N/A	
Physician Office Visit				
Primary Care	80% (DA)	60% (DA)	$25 copay (DW)	80% (DA)
Specialty Care	80% (DA)	60% (DA)	$40 copay (DW)	80% (DA)
Preventive Care				
Preventive Exams	100% (DW)	Not Covered	100% (DW)	Not Covered
Diagnostic Services				
X-ray and Lab Tests	80% (DA)	60% (DA)	80% (DW)	80% (DA)
Complex Radiology	80% (DA)	60% (DA)	80% (DW)	80% (DA)
Hospital and Emergency				
Urgent Care (Stand Alone)	80% (DA)	60% (DA)	$40 copay (DW)	60% (DA)
Emergency Room	80% (DA)		*ER copay is new as of 01/01/2027* $250 copay 80%, (DA) Copay waived if admitted	
Inpatient Facility Charges	80% (DA)	60% (DA)	80% (DA)	60% (DA)
Mental Health & Substance Abuse				
Inpatient	80% (DA)	60% (DA)	80% (DA)	60% (DA)
Outpatient Office Visit	80% (DA)	60% (DA)	$25 copay (DW)	60% (DA)
Other Services				
Chiropractic, Acupuncture 12 visits PCY**	80% (DA)	60% (DA)	$25 copay (DW)	60% (DA)
Rehabilitation Services				
Inpatient – 30 days PCY	80% (DA)	60% (DA)	80% (DA)	60% (DA)
Outpatient – 45 visits PCY	80% (DA)	60% (DA)	$40 copay (DW)	60% (DA)

*(DW) = Deductible Waived, (DA) = Deductible Applies, **PCY = Per Calendar Year
*** The deductible on the Health Savings Plan is shared among all family members.

Pharmacy Benefit

Retail Pharmacy – (Up to a 90 Day Supply) one copay per 30 day supply				
	Health Savings Plan		**Traditional Plan**	
	Member Cost Share		Member Cost Share	
Formulary	A1		B3	
Medical Deductible Applies	Yes		No	
	Contracted Pharmacies	**Non-Contracted Pharmacies**	**Contracted Pharmacies**	**Non-Contracted Pharmacies**
Generic	20% (DA)*	20% (DA)	$15 copay (DW)**	Copay + 40%
Preferred Brand	20% (DA)	20% (DA)	$50 copay (DW)	Copay + 40%
Non-Preferred Brand	20% (DA)	20% (DA)	$80 copay (DW)	Copay + 40%
Specialty	Same as retail schedule above		Same as retail schedule above	
Mail Order Pharmacy (90 Day Supply)				
Generic	20% (DA)	Not covered	$30 copay	Not covered
Preferred	20% (DA)	Not covered	$100 copay	Not covered
Non-Preferred	20% (DA)	Not covered	$160 copay	Not covered
Specialty	Dispensing Limits apply for Specialty Medications and may not qualify for mail order			

*(DA) = Deductible Applies **(DW) = Deductible Waived

Keep your medications cost down with these tips

The high expense and use of medications is one of the main factors contributing to rising health care costs. Premera members have access to a broad retail pharmacy network to take advantage of the most competitive options.

1) **Choose Generics** – Generic medications have been proven to be as effective and safe as brand-name drugs. They contain the same active ingredients and are available in the same strength and dosage. Before filling a prescription, always ask your provider or pharmacist if a generic is available.

2) **Use Mail Order** – Save time and money by using mail order. Have maintenance medications delivered right to your home by Express Scripts. Before requesting a change to mail order delivery, make sure you have a two-week supply of your prescription available.

   Online:

   - Go to Manage Prescriptions page.
   - Follow the steps under "Change current prescriptions to mail order."
   - Go to Express Scripts
   - Choose which medication you want to switch to a 3-month supply
   - Express Scripts will contact your provider and request a new mail-order prescription.
   - Contact Express Scripts by phone at (800) 391-9701 or by mailing the completed form to Express Scripts.

     Premera Blue Cross Home Delivery Order form (PDF document)

Lower Cost Care Options for Premera Members

You will have convenient, anywhere access to your health plan information with Premera's mobile app. With the app, you can find information on where to go for in-network hospitals, physicians and clinics. Access your digital ID card to show proof of coverage and view your claims for detailed information. Access virtual primary care or mental health providers for in person virtual care day or night. If you are enrolled in the Health Savings Plan the deductible may apply to your virtual visit. Sign into the Premera mobile app and access virtual care from the Find Care section.

transcarent	**Feel Better fast!** • Chat with a doctor virtually day or night • quickly get the care you need 24/7 • Includes treatment for primary or urgent care • Prescriptions can be sent to your preferred pharmacy • Activate your account online webapp.transcarent.ai/activate
Spring Health	**Schedule your own virtual counseling appointments** • Easy and reliable access to care in just 1 to 2 days by video or phone • Get care for yourself, your dependents for family therapy, substance abuse, psychiatric evaluations and medication management. **Get started** • Create an account online or by downloading the app – it only takes a few minutes. • Review provider profiles and choose the provider you think will meet your needs **Take Action** • Use the online scheduling tool to choose the available dates and times • Explore the Spring Health library of self-guided exercises to build skills www.springhealth.com/connect | Spring Health App Download on the App Store GET IT ON Google Play Members ages 6 and older can get mental health therapy by phone or video chat. Psychiatric and medication management are also available for members ages 18 and older.
Talkspace	With Talkspace you can easily connect to therapists and psychiatrists by video and text for about the same costs as an in -person visit. When you need Talkspace – regardless of the time of day or where you are – you can reach your dedicated therapist. **Here is how to get started:** • Sign up to Talkspace at talkspace.com/premera.com • Get matched with the best therapist for you • Start messaging your therapist right away. Access Talkspace via the Premera mobile app.
Boulder	Boulder is a digital clinic that offers long-term support and telehealth treatment for substance abuse, including alcohol and opioid use disorders. Treatments are grounded in kindness, respect, and unconditional support. Sign in to your account via the Premera mobile app.

Frequently Asked Questions

What's A Deductible?

A deductible is the amount of money you or your covered dependents must pay toward a health claim before your insurance company makes payments for health care services rendered. For example, if you have a $600 deductible, you would be required to pay the first $600, in total, towards any applicable claims during a plan year. This plan's deductible runs on a calendar year. Not all covered services have deductibles applied.

What's Coinsurance?

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible. For example, a medical plan may pay 80% and the member pays 20% for certain services.

What's An Out-Of-Pocket Maximum?

The maximum amount (deductible, copay and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

What Does In-Network Mean?

In-network refers to providers or facilities who have contracted with an insurance carrier to provide services at negotiated (discounted) rates. By utilizing in-network providers/facilities you will pay less out-of-pocket, and you will not be required to file a claim for reimbursement. Research Premera contracted providers in the Heritage network at [www.premera.com.](http://www.premera.com)

What Should I Ask My Doctor?

Many patients do not ask their doctor basic questions. Having a dialogue with your physician can help you better understand and prepare for potential out-of-pocket expenses. Questions such as:

"How much will my treatment cost?"
"What are the risks?"
"What are the side effects?"

By asking these types of questions it will help your doctor get to know you better and consequently prescribe treatment that is more effective.

What's Preventive Care?

Preventive care is important proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Preventive care is covered at 100% in-network.

What Is an Explanation of Benefits?

An EOB is a statement the insurance company sends to you explaining the health care charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.

What Is the Difference in Drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

What Are Mail Order Drugs?

Mail order drugs are perfect for patients who take long term maintenance medications such as high blood pressure medication, high cholesterol medication, insulin and birth control. Mail Order is convenient because they are delivered to your doorstep which relieves the stress of standing in line at the pharmacy.

What is a Pre-Authorization?

Prior Authorization is an approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

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Helping You Choose the Right Type of Care

Do you know where to seek care when an unexpected health situation happens? Make sure you are ready when you have to make a quick healthcare decision. Review some of the choices of care that are available, so you know where to go the next time you need treatment.

Being prepared is important because knowing where to go for care can help you receive faster treatment and an overall better experience. Always be sure to seek care from In-Network providers to lower your out-of-pocket expenses.

Know Before You Go!
Find a provider at:
Premera.com



Virtual Primary Care Transcarent

- Available 24/7
- Minor illnesses
- Minor infections
- Cold & flu
- Allergies
- After-hours care
- Via phone or web
- **Lowest cost option!**







Doctor's Office

- Routine care
- Immunizations
- Flu shots
- General health management
- Easy point of entry to health care
- Knows your health history
- No costs for In-Network preventive care





Premera, Kinwell Primary Care Clinics

- In-person and virtual appointments
- Primary care and behavioral health under one roof
- Same and next day virtual visits
- Easy online scheduling and standard lab services

Premera Members save with **Kinwell Primary Care**.





Urgent Care Clinic

- Minor illness or injury and your doctor is not available
- You need care quickly, but it's not an emergency
- Sprains
- Strains
- Minor broken bones
- Minor infections
- Minor burns
- Shorter wait time than emergency room
- Xray & Lab Services
- Open evenings & weekends





Emergency Room

- Immediate treatment of a serious or critical condition
- Uncontrolled bleeding
- Large wounds
- Chest pain
- Signs of heart attack
- Spinal injuries
- Severe head injury
- Difficulty breathing
- Possible stroke

Do not ignore an emergency.
If a situation seems life-threatening
call 911
or your local emergency number right away.



Health Savings Account (HSA)

When you are enrolled in the Health Savings Plan and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account. Access the HSA through your Premera member account at www.premera.com/hsa. Premera contracts with Optum Bank to manage employee Health Savings Accounts.

Coverage Tier	2026 Calendar Year Contribution Limits*	2027 Calendar Year Contribution Limits*
Employee Only	$4,400	$4,500
Employee + Dependent(s)	$8,750	$9,000
Additional Catch-Up Contribution	$1,000 per year if over the age of 55	

NWC 2027 Contribution	Self Only Coverage	Family Coverage
Annual Total Employer Contribution	$1,000	$2,000
Initial Employer Contribution (1/1/2027 or enrollment date)	$250	$500
Per remaining 23 pay periods	$32.61	$65.22

If you open your HSA after the calendar year has started, your maximum contribution for that year will be prorated based on number of months left in the year. For example, if you open your HSA as of September 1, you may not contribute more than 4/12 of the maximums shown above.

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn interest, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although all benefit eligible employees can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

Requirements to enroll in a Health Savings Account

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP) like the one offered by your employer.
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Non-Preventive Veterans Administration (VA) benefits or IHS within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. Participation in a limited purpose health care FSA is allowed.



Dental Insurance

Northwest Center offers a comprehensive dental plan with Delta Dental of Washington.

Any member who receives a Class 1: Preventive service will increase their benefit maximum by $250 the following year. Preventive services can include a cleaning, fluoride treatment, x-rays, and sealants. The increase is cumulative. Members can earn an extra $250 each year up to a maximum of $2,500. Each year you don't get a Class 1: Preventive service your benefit maximum decreases back to the previous year's level but will not drop below $1,500.

Benefit Coverage	Delta Dental PPO Plan		
	Preferred	Premier	Out-of-Network
Calendar Year Deductible (Waived for Preventive Services)			
Individual	$50 Individual		
Family	$150 Family Maximum		
Calendar Year Benefits			
Per Person Benefit Maximum	Base: $1,500 Annual Increase for Healthy Checkup: $250, Maximum: $2,500 Increases apply the following calendar year benefit		
Class I: Preventive Exams, Cleanings, X-rays, Fluoride and Sealants	100%	80%	80% MAC*
Class II: Restorative Fillings, Root Canal, Periodontics, Extractions	80%	70%	70% MAC
Class III: Major Crowns, Dentures, Partials, Bridges and Implants	50%	40%	40% MAC
Orthodontia (Adults & Children)	50% to a lifetime maximum of $1,500		

*MAC – Maximum Allowable Charge

The level of benefits received is based on whether that treatment was provided by a preferred, premier or out-of-network dental provider. Benefits are payable at the preferred level by accessing your care through a Contracted Provider. Out-of-network charges will be paid at a set reimbursement amount, also called the Maximum Allowable Charge. If you use an out-of-network dentist, that provider may bill you over and above the set reimbursement amount. This is a common practice called balance billing and may lead to unexpected dental costs.



Find a PPO dentist

- Visit deltadentalwa.com
- Click on Online Tools and Find a Dentist
- Fill in your address, select the Delta Dental PPO, and click on Search

Activate your FREE MySmile account

Get started at DeltaDentalWA.com/mysmile.com. Review your coverage overview, benefits usage, claims status and Explanation of Benefits (EOBs). Access the easy-to-use tools:

- Digital ID Card
- Find a Dentist
- Cost Estimator

Still have questions?

Call Delta Dental at (800) 554-1907

Vision Insurance



Northwest Center provides you with the opportunity to purchase vision coverage for yourself and your eligible dependents through Vision Service Plan (VSP). To find a participating provider in VSP **Signature** provider network or to review your benefits before an appointment, visit www.vsp.com or call (800) 877-7195. VSP does not issue ID Cards. Your preferred provider will locate your coverage electronically.

Out-of-Network benefits are available. See your summary for a reimbursement schedule when you use an out-of-network service provider.

Service	Vision Plan
Copays	**In Network**
Exam	$10 copay
Prescription Glasses (Frame and Lenses)	$10 copay combined with Exam
Vision Materials	
Prescription Lenses (Once every 12 months)	Single vision, lined bifocal, lined trifocal and standard progressive lenses paid at100% after combined copay
Lenses	
Elective Contact Lenses Instead of glasses (Once every 12 months)	$135 allowance for contacts; copay does not apply Up to a $60 copay for contact lens fitting and evaluation
Frame	
Frame (Once every 24 months)	$150 frame allowance or $170 for featured frames (20% savings on the amount over your allowance) $150 frame allowance Walmart or Sam's Club, $80 Costco frame allowance

Additional Pairs of Glasses and Sunglasses



Discover all current eyewear and savings at vsp.com/offers

- 40% off lens enhancements
- 20% off on additional pairs of glasses and sunglasses
- Shop online and save with Eyeconic. Use your benefits at www.eyeconic.com the preferred VSP online retailer.

Online

- Guaranteed pricing on your retinal screening as an enhancement to our WellVision Exam.

Laser Vision Correction

- Average of 15% off the regular price: discounts available at contracted facilities

Exclusive Member Extra for VSP Members

- Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers
- Save up to 60% on digital hearing aids through TruHearing. Visit vsp.com/offers for details.

Basic Life and Accidental Death and Dismemberment (AD&D)

We provide a basic life and accidental death & dismemberment (AD&D) insurance benefit to all eligible employees with The Hartford. Enrollment is automatic and NWC pays the full cost of your coverage. Life insurance pays your beneficiary a benefit in the event of your death and AD&D insurance pays a benefit if your death results from an accident or if you are severely injured in an accident.

Basic Life/AD&D	
Coverage Amount	
Employee Basic Life Benefit	$10,000
Employee Basic AD&D Benefit	$10,000
Benefit Reductions due to Age	Reduced to 65% at age 65, and to 50% at age 70

Voluntary Life and AD&D Insurance

Northwest Center offers all eligible employees the opportunity to purchase life and AD&D insurance through The Hartford. This benefit is employee-paid through convenient payroll deductions.

If you would like to purchase coverage in excess of the guarantee issue amounts, or if you apply for coverage after your initial eligibility period, you will need to answer health related questions to provide proof of insurability.

Certain delays in coverage may occur if you are not actively at work, or if your dependents are confined to a medical facility or unable to perform, unaided, the normal functions of daily living. See the voluntary life policy for more information.

Voluntary Life/AD&D		
The Insured	**Maximum Coverage Amount**	**Guarantee Issue**
For You	Up to 5 times your basic annual earnings or $500,000, in increments of $1,000	$150,000
For Your Eligible Spouse/DP	Up to $500,000 in $1,000 increments. May not exceed 100% of employee's amount.	$25,000
For Your Eligible Children	Up to $10,000 in $1,000 increments for children age 6 months to 26 years. $1,000 for children age from birth to 6 months.	$10,000

The cost of voluntary life and AD&D insurance depends on the amount of coverage and ages of the employee and spouse.

Employee (or spouse age band)	Employee Cost Per $10,000	Spouse Cost Per $5,000
15 - 24	$0.700	$0.290
25 - 29	$0.800	$0.330
30 - 34	$0.990	$0.415
35 - 39	$1.400	$0.605
40 - 44	$2.000	$0.865
45 - 49	$3.200	$1.355
50 - 54	$5.080	$2.115
55 - 59	$7.820	$3.240
60 - 64	$12.190	$5.540
65 - 69	$21.170	$9.465
70 - 74	$37.770	$16.865
75 +	$74.020	$33.785



The rate for children is $0.732 per $2,000 of life coverage and $0.04 per $2,000 of AD&D coverage. One monthly premium amount insures all of your eligible children.

Flexible Spending Arrangement (FSA)

January – December Plan Year

Provided by Navia Benefit Solutions

Flexible spending accounts, or FSAs, are tax-advantaged accounts that allow you to pay for medical or dependent care expenses. Depending on the extent of your health care or dependent care costs, an FSA can help you save a lot of money on taxes, particularly since the list of eligible expenses has expanded in recent years. The FSA plan year is January to December.

Health Care FSA

The Health Care FSA allows you to set aside pretax money for eligible medical expenses that you would normally pay using personal funds. These expenses include deductibles, copays, or coinsurance not reimbursed by any medical, dental, vision, or prescription plans for you, your spouse, or eligible dependents and many over the counter items not covered by traditional health insurance.

Key Features of The Healthcare FSA

- The IRS sets the maximum amount you can elect each year. The 2027 amount is $3,500.
- Annually the IRS will set the limit on how much unused healthcare FSA funds can roll over to the next plan year. For 2027 that amount is $700. Any funds in excess of $700 as of December 31 will be forfeited. This is referred to as the Use-it-or-lose-it rule.
- The full amount of your FSA election is available the first day of the plan year and you pay back the total elected amount via payroll deductions.
- Claims for reimbursement incurred during the plan year need to be submitted within 90 days after the end of the plan year.
- FSA elections, once made, cannot be changed for the entire plan year without a qualified family status event.
- FSAs do not move with you upon termination of employment. You would need to elect COBRA to access your FSA.
- You do not own this account.
- Requires annual enrollment to participate.
- Once enrolled you will receive a debit card from Navia loaded with the amount you elected to be used for paying for eligible expenses. The FSAstore and Amazon FSA offer a wide variety of eligible items for easy online shopping.
- You cannot enroll in a general-purpose Healthcare

Navia Online Tools & Resources
www.naviabenefits.com
customerservice@naviabenefits.com
(800) 669-3539 | (425) 452-3500

Day Care / Dependent Care FSA

The Day Care/Dependent Care FSA allows you to contribute up to $7,500 per household, $3,750 if married filing separately for qualified dependent care expenses. You and/or your spouse must be working full-time, looking for work, or be a full-time student to participate in the Dependent Care account. Day Care funds may be used for expenses relating to children age 12 and under who live with the account holder more than half the year. Day Care funds may also be used for dependents of any age incapable of self-care. Examples of qualified Day Care providers are daycare centers, before/after school care, or day camps. Although you may not take the IRS childcare tax credit if you choose this option, you may benefit more under this plan, depending upon your income level. Please refer to a tax advisor for more information about which option is best for you.

Key features of the Day Care / Dependent Care FSA

- Only amounts that have been contributed can be withdrawn.
- FSA elections, once made, cannot be changed for the entire plan year without a qualified life event.
- You do not own this account.
- Your Navia debit card will be loaded each pay period with the amount elected to contribute per paycheck.
- There is no roll over feature, it is a Use-it-or-lose-it rule.

Ways To Access Your FSA Online Portal

Navia's participant portal gives you complete access to your benefit accounts. Submit claims, get alerts and notifications, view account balances, your account history, and access our customer service.

MyNavia Mobile App

Whether you're at the doctor's office or on vacation, the MyNavia app allows you to manage and access your benefits right from your smartphone! Available for iPhone and Android devices.

Navia Debit Card

The Navia Benefits Card is a Debit MasterCard that allows you to access your benefit funds directly. Instead of paying out-of-pocket and waiting for a reimbursement, your expense is paid directly from your plan to the provider!

Mobile Pay

Add your Navia debit card to your digital wallet to use tap-to-pay technology for contactless payments!

GoNavia Commuter

GoNavia is an online commuter platform allowing members to allocate up to $350 each for transportation and parking expenses due to work travel. Use your GoNavia debit card to pay bus passes, smart cards, monthly parking permits etc.

CuraLinc EAP

Prioritize your wellbeing. Log in to take the next step in your wellbeing journey. Starting January 1, 2027, CuraLinc is available to **all employees** regardless of medical plan enrollment. If you utilized Spring Health providers and are not enrolled either of the Premera Blue Cross medical plans, we invite you to try CuraLinc as a short term mental health solution.

Call for assistance (800) 553-7798 or connect online at www.mysupportlinc.com, group code **northwestcenter**.

Connect to care your way

- Reach a licensed clinician by phone 24/7/365 when you call for in-the-moment support
- Access no-cost short-term counseling in person or by video for concerns such as stress, anxiety, depression, burnout or substance use
- Message a Coach to boost your emotional fitness, learn healthy habits, increase resilience and more

Simplify your everyday life with work-life benefits

- Get expert consultations for financial and legal concerns
- Receive referrals for needs such as child or elder care, pet care, home improvement or auto repair

Prefer digital access? No problem!

The web platform and mobile app make it easy to connect to care and strengthen your wellbeing

- Create a personalized profile for resources tailored to your needs
- Understand your emotions and receive help with mental health check-ins
- Schedule sessions with a licensed clinician via in-person, video or text
- Attend anonymous group sessions for support and connection in a safe, text-based space
- Track your mood and journal to build self-awareness and notice progress

Physical Wellness Reimbursement

Provided by Northwest Center

All NWC employees working at least 30 hours/week are eligible for our physical wellness reimbursement program. Please contact benefits@nwcenter.org for the enrollment form.

Benefit	$25/month for a total reimbursement of $300/year
Allowed expenses	• **Gym membership** (any gym of your choice) • **Exercise classes** (yoga, cross fit, barre, etc.) • **Workout equipment** (weights, yoga mat, jump rope, bike, etc.) • **Athletic event registration fees** (coordinated runs, bike races, etc.) • **Sport lessons/league fees** (tennis lessons, basketball league, etc.)





Northwest Center 401(K) Retirement Plan

Effective Plan Dates: **Jan 1, 2027 — Dec 31, 2027**

Northwest Center offers retirement plans that allow you to save money and take an active role in your financial future. A 401(K) is an employer-sponsored retirement savings plan named after Section 401(K) of the U.S. Internal Revenue Code. A 401(K) allows you to automatically invest a portion of each paycheck into mutual funds, exchange traded funds (EFTs) or other assets for long-term growth. Most employees are eligible to participate right away!

Employee Contribution
The money you elect to set aside is deducted directly from your paycheck. Employees can contribute up to the current IRS limits with an additional catch up contribution if age 50 or older.

Employer Match
NWC provides a 50% match up to the first 6% of employee investment following 12 months of employment.

Vesting
Your vesting percentage determines how much of Northwest Center's matching contributions you keep when you leave.

Year of vesting service	Percentage you keep
Less than 1 year	0%
1 year	25%
2 years	50%
3 years	75%
4 or more years	100%

You also become 100% vested if you are employed by Northwest Center when you reach normal retirement age, become totally disabled as defined by the plan, or pass away.

Your own contributions are always 100% yours.

Rollovers, Loans, and Withdrawals

For questions or assistance with rollovers, loans, or withdrawals, please contact Principal directly through your account at www.principal.com

Ways to Enroll

- **Visit principal.com/welcome** or,
- Download the Principal mobile app or,
- Text ENROLL to 78259

Additional Benefits

Voluntary Accident
Provided by The Hartford

Accident insurance can pay you a lump-sum benefit based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job, including a wide range of common and serious injuries and events (e.g. fractures, emergencies, surgeries, coma, etc.).

Voluntary Critical Illness
Provided by The Hartford

Critical illness insurance can pay you a lump-sum benefit at the first diagnosis of a covered illness. You can use the benefit however you choose – even for expenses like your medical plan deductible, mortgage, rent, or childcare. Illnesses covered by the plan include heart attacks, strokes, major organ transplants, end-stage renal (kidney) failure, permanent paralysis due to a covered accident, and more.

Washington Paid Family Leave
Provided by the state of Washington

Workers in Washington may apply for paid leave benefits under the state's Paid Family & Medical Leave (PFML) program. In general, eligible employees may take up to 12 weeks of paid leave per year to care for themselves, their family members, or to bond with new children. For information about eligibility or how to apply for benefits, please refer to the state's website at paidleave.wa.gov/workers.

Student Loan Contribution Program
Provided by Northwest Center

All NWC employees working at least 30 hours/week are eligible for our student loan contribution program through SoFi. NWC will make a $50 monthly contribution toward your eligible student loan. Sign up at sofi.com/at-work/lookup.

Employees without student loans have access to educational tools, exclusive offers, and benefits via the SoFi at Work Dashboard. Improve your credit score, track your spending, or just browse the vast array of educational content to help you achieve your financial goals.

This brochure summarizes the benefit plans that are available to Northwest Center eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 this plan. Therefore, the following In-network deductibles and coinsurance apply:

Individual Deductible	Health Savings Plan	$2,000	Traditional Plan	$600
Family Deductible		$4,000 (Shared)		$1,800
Coinsurance		Plan Pays 80%		Plan Pays 80%

NEWBORNS ACT DISCLOSURE – FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

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:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

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.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or 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 (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Bobbie Benavente
1119 SW 7th Street
Renton, WA 98057
(253) 486-0065
mailto:Benefits@nwcenter.org

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice.
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- January 1, 2027
- Bobbie Benavente: benefits@nwcenter.org (253) 486-0065

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/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 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) 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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – 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)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
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, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 10.22% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-26-26.pdf for 2027.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Northwest Center Industries
Contact--Position/Office:	Bobbie Benavente / Sr. Manager, Healthcare and Retirement Benefits
Address:	428 Westlake Ave N, Seattle, WA 98109
Phone number:	(253) 486-0065

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Northwest Center Industries	4. Employer Identification Number (EIN) 91-0786790	
5. Employer address 1119 SW 7th Street, Renton, WA 98057	6. Employer phone number (253) 486-0065	
7. City Renton	8. State WA	9. ZIP code 98057
10. Who can we contact about employee health coverage at this job? Bobbie Benavente – Sr. Manager, Healthcare and Retirement Benefits		
11. Phone number (if different from above)	12. Email address Benefits@nwcenter.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full-Time employees expected to work at least 30 hours per week each calendar month are eligible for benefits. You will be eligible as a new Full-Time employee the 1st of the month coinciding or following 30 days of continuous employment.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Eligible dependents include your spouse, domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided within 120 days after the date on which maximum age is attained. Children may include natural, legally adopted, stepchildren and children obtained through court-appointed legal guardianship.
  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premium.