2025 Employee Benefits

Plan well, live healthy

ONLINE RESOURCES

You can download a copy of this booklet to your computer or smart phone by following the link below:

https://alliantbenefits.cld.bz/BonnerC2025Benefits

CONTENTS

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Getting Started

2025-2026 Benefits

Effective October 1, 2025

Medicare Part D Notice

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

No matter where you are in your career, Bonner County supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

Who's eligible for benefits?

Employees:

You are eligible if you are a full-time employee working 20 or more hours per week.

Eligible dependents:

- Legally married spouse
- Biological, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit.

When can you enroll?

You can enroll in benefits as a new hire or during the annual open enrollment period.

If hired the 1st - 15th, coverage begins on the first of the following month. If hired the 16th - 31st, coverage begins on the first of the month following 30 days as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

Click to play video

Life happens

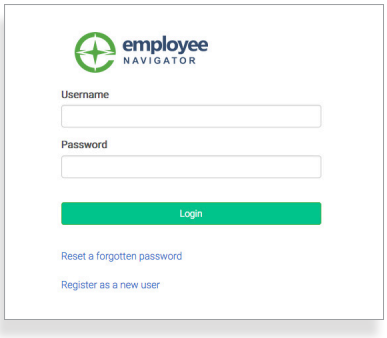
A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit any changes within 30 days after the event.

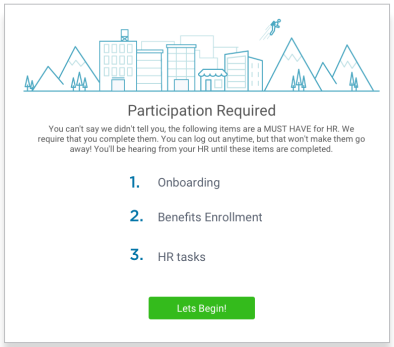
ENROLL IN YOUR BENEFITS: One step at a time



Step 1: Log In

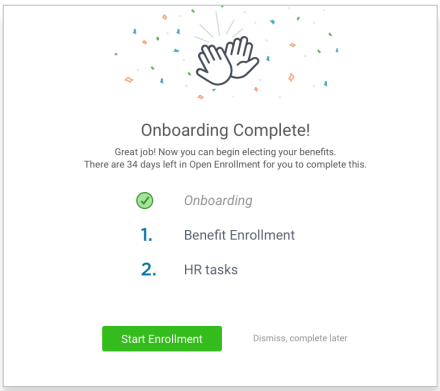
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- **Our Company ID** - BonnerCounty



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

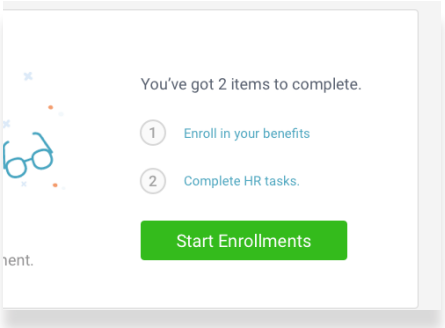


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

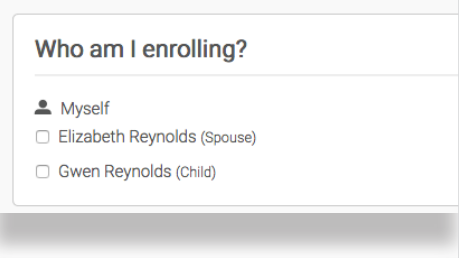
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

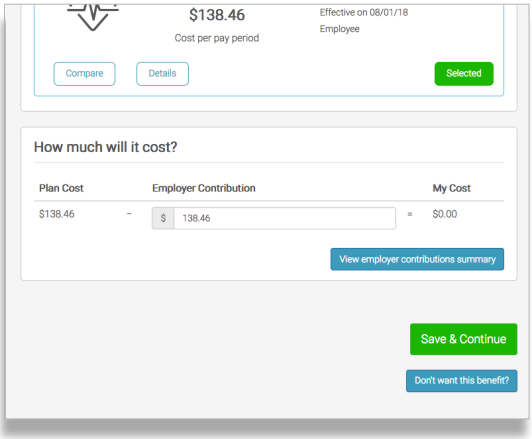
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

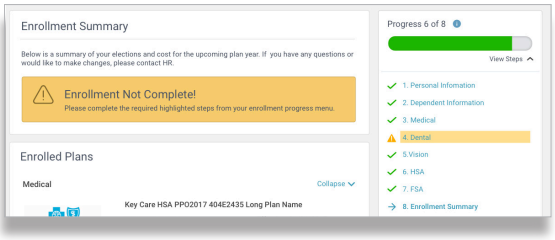


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

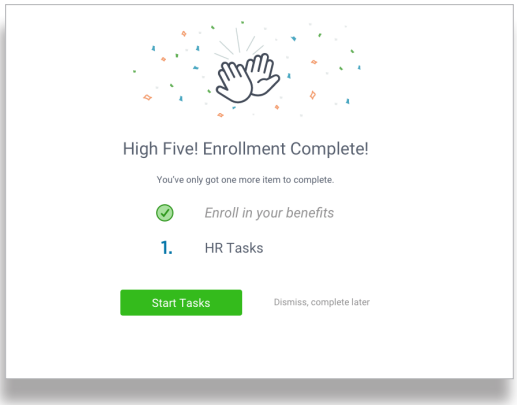


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

Medical

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

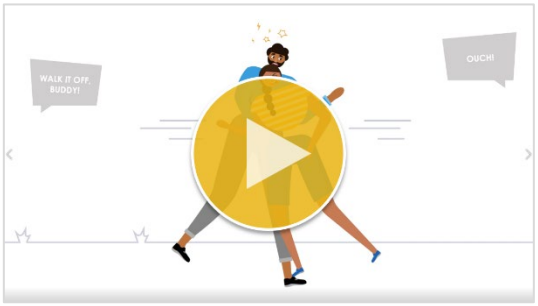
Regence Blue Shield of Idaho

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

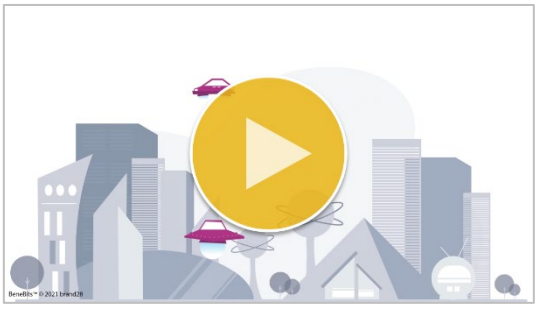
In-Network Benefits	PPO Plan	HSA Individual Plan	HSA Family Plan
Annual Deductible	$1,500 per individual $3,000 family limit	$2,000	$3,300 per individual $5,200 family limit
Annual Out-of-Pocket Maximum	$5,000 per individual $10,000 family limit	$4,000	$4,000 per individual $8,000 family limit
PCP Office Visit	$30 copay	20% after deductible	20% after deductible
Specialist Office Visit	$45 copay	20% after deductible	20% after deductible
Chiropractic	20% coinsurance (deductible waived) (up to 20 visits per year)	20% after deductible (up to 20 visits per year)	20% after deductible (up to 20 visits per year)
Lab and X-ray	20% after deductible	20% after deductible	20% after deductible
Urgent Care	$30 copay then 20% coinsurance	20% after deductible	20% after deductible
Emergency Room	$100 copay then 20% after deductible (copay waived if admitted)	20% after deductible	20% after deductible
Hospitalization	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	In ASC: 10% after deductible; others: 20% after deductible	In ASC: 10% after deductible; others: 20% after deductible	In ASC: 10% after deductible; others: 20% after deductible
PRESCRIPTION DRUGS			
Rx Deductible	$250 per individual	Medical deductible applies	Medical deductible applies
Retail Pharmacy			
Tier 1	$15 copay after Rx deductible	20% after deductible	20% after deductible
Tier 2	$30 copay after Rx deductible	20% after deductible	20% after deductible
Tier 3	$45 copay after Rx deductible	20% after deductible	20% after deductible
Tier 4	$200 copay after Rx deductible	$200 copay	$200 copay

Engage

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs
- Express Scripts Home Delivery

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

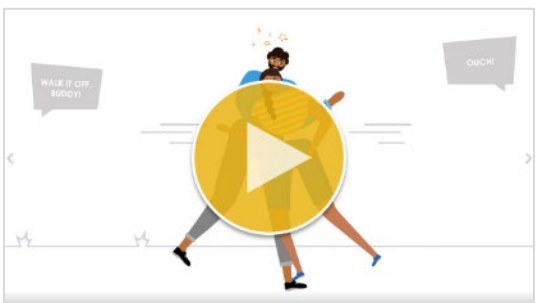
- Doctor On Demand - Telehealth

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for ...
Online visit ($) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to $4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive care

You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Regence

IDAHO

Preventive care

In-network services covered at 100%

Most Regence members have 100% coverage for preventive services—care that detects an issue before it becomes a problem. You'll pay nothing for the care listed here when you see an in-network provider. We follow recommendations from three government agencies to determine which services we cover.[1]

You may have to pay for covered preventive care if:

- You see an out-of-network provider
- Your doctor provides preventive care outside the guidelines
- Your provider doesn't obtain any required pre-authorization (for example, physical therapy for fall prevention, genetic testing for BRCA 1 and 2 and lung cancer screening)

Also, diagnostic services are different from preventive. Diagnostic care looks at a problem you're already having. So ask your doctor if services are preventive or diagnostic. It's important to know because you may have to pay out of pocket for diagnostic care.

Check the list below to see which preventive services most of our plans cover. Some plans may have limitations or not cover all of these services. Check your plan benefits or call Customer Service at the number on the back of your member ID card if you have questions.

1. These scientifically supported guidelines are created by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA).

Members of all ages

The following services are provided as appropriate to need and age.*

Lab tests

- Cholesterol screening (if high risk)
- BRCA 1 and 2 testing and counseling (if high risk and meet criteria)
- Hepatitis B screening (if increased risk)
- Hepatitis C screening (if high risk or age 18–79)
- HIV screening (15–65 or high risk)
- HIV PrEP screening
- Sexually transmitted disease counseling during wellness exams
- Screening for gonorrhea, syphilis and chlamydia
- Tuberculosis screening
- Prediabetes and type 2 diabetes screening and counseling (35–70 if overweight or obese)

Procedures

- Abdominal aortic aneurysm screening (men only, 65+ and have ever smoked)
- Cervical cancer screening (Pap) (21+)
- Colon cancer screening (45+)
- Lung cancer screening (50–80 with history of smoking)
- Osteoporosis screening (women 65+ or at risk)
- Physical therapy to prevent falls (in community-dwelling adults 65+ and at high risk)
- Screening mammogram (40+ or at high risk)
- Sterilization (tubal ligation)

Examinations / counseling

- Annual wellness (physical) exam (18+)
- Blood pressure monitoring (18+)
- Breast cancer prevention counseling (if high risk)
- Depression screening during wellness exams
- Diabetes counseling (40–70 if overweight or obese)
- Diet behavior counseling (for those with hyperlipidemia)
- Heart disease prevention counseling (18+ with additional cardiovascular disease (CVD) risk factors)
- HIV counseling (15–65 or at high risk)
- HPV screening every three years (30+)
- Interpersonal and domestic violence screening and counseling during wellness exams
- Obesity counseling in midlife (40–60)
- Obesity screening and counseling
- Sexually transmitted disease counseling during wellness exams
- Tobacco-use counseling (not programs or classes)
- Unhealthy alcohol and/or drug use screening and behavioral counseling (18+)

Immunizations

- Chicken pox (varicella)
- Diphtheria, pertussis (whooping cough), tetanus (DPT)
- Hemophilus influenzae type b (Hib)
- Hepatitis A and B
- Herpes zoster (shingles) (19+)
- HPV (up to 45)
- Influenza (flu)
- Measles, mumps, rubella (MMR)
- Meningitis
- Pneumonia
- Smallpox / monkeypox

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

Pregnant members

During pregnancy, members may receive preventive services described under "Members of all ages," plus the following:

Lab tests

- Anemia screening
- Gestational diabetes screening
- Hepatitis B screening
- HIV screening and counseling
- Rh(D) incompatibility screening
- UTI screening

Breastfeeding / chestfeeding supplies and support

- Breast pump / lactation pump (non–hospital-grade)
- Lactation support and counseling

Examinations / counseling

- Counseling to promote healthy weight gain during pregnancy

Children

Children may receive age-appropriate* preventive services described under "Members of all ages," plus the following:

Newborns (up to 62 days of age)

- Congenital hypothyroidism screening
- Gonorrhea medication for the eyes
- Jaundice (bilirubin) screening
- Metabolic screening
- PKU screening
- Sickle cell anemia screening

Youths (up to 21)

Anemia screening

Dyslipidemia (high cholesterol and fat in blood)

Lead poisoning screening

Examinations / counseling

- Dental caries (up to age 6, starting when first tooth appears)
- Eye exam (3–5)
- Fluoride varnish (up to age 6 when applied by primary care clinician)
- Interventions for children and adolescents (6+) with high body mass index
- Newborn hearing screening (up to 62 days)
- Skin cancer counseling (6 months–24 years for those with fair skin type)
- Well-child exams (up to age 18)

Immunizations

- Children may receive age-appropriate immunizations described under "Members of all ages," plus the following:
- Polio
- Rotavirus

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

Contraception for women

- Birth control education and training
- Contraception mobile application, FDA-approved only

Our prescription drug benefit covers all forms of FDA-approved birth control. For a complete list, visit regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html. Religious exemption: Birth control coverage may not be available if the group you have coverage through has a religious exemption.

Prescription drugs

Your preventive care benefits cover many over-the-counter and prescription drugs.

To learn more, visit regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html and go to the ACA Preventive Medications, Covered Contraceptive Products and Tobacco Cessation coverage lists.

.com

To learn more, go to **regence.com**. For your plan benefits, see your benefit booklet or call us at the number on the back of your member ID card.

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Regence BlueShield of Idaho
1602 21st Avenue | Lewiston, ID 83501

REG-ID-1545527-25/04

Prescriptions breaking your budget?

Click to play video

The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

EXPRESS SCRIPTS MAIL ORDER

Skip the trips to the pharmacy

With home delivery, you won't miss wandering the aisles waiting for your medication to be ready—or standing in line for a pickup. Your Regence health plan offers access to Express Scripts, so you can get your long-term medications delivered right to your door with free standard shipping. It's a safe, convenient way to fill your prescriptions and might even save you money.

What you get with Express Scripts

- 24/7 access to a team of knowledgeable pharmacists and support staff
- Free standard delivery
- Tamper-proof, unmarked packaging
- Refill reminder notices through your phone or email, whichever you prefer
- Multiple locations across the U.S. for fast processing and dispensing

Convenience that comes to you

You'll receive most medications within seven to ten days after you place your first order. Refills may take up to seven days to arrive. You may be able to stock up on your long-term medications with a 90-day supply—one more way to cut down on your trips to the pharmacy.

Get started

Here's how to set up home delivery:

1. Go to express-scripts.com/rx to register and create a profile. Or you can call an Express Scripts health care advisor at 1-833-599-0451 for assistance setting up your profile. You can also download the Express Scripts app to manage your prescriptions.

2. Once you've registered and created your profile, ask your doctor to send a prescription to Express Scripts.

Questions?

Call the Customer Service number on your member ID card. We're open 24 hours a day, seven days a week.

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Express Scripts is a separate company that provides pharmacy benefit management services.

Regence BlueShield of Idaho
1602 21st Avenue | Lewiston, ID 83501

REG-ID-730093-24/12

Telehealth for medical and behavioral health care

Doctor On Demand provides convenient care when you need it

Visit a doctor or therapist via video chat

We all have times when we need to see a doctor, but it's inconvenient—there's no time, the office is closed, or we're on the road. You know that feeling: "I wish I could get care without leaving the house!" Now you can.

Your health plan includes telehealth powered by Doctor On Demand, a national leader in quality care. You can talk to any of Doctor On Demand's board-certified physicians, licensed counselors and psychiatrists by video chat using your computer or the app—7 days a week, 365 days a year.

Regence

Telehealth for medical and behavioral health care

Care you can count on

You'll connect with board-certified doctors and therapists who can diagnose and treat non-emergency medical conditions, mental and behavioral health needs, prescribe medications, and send prescriptions to your pharmacy. With specialties including primary care, pediatrics, family medicine and behavioral health, Doctor On Demand makes it easy to get quality care for every member of your family.

Common ailments treated via telehealth include:

Medical

Allergy
Cold and flu
Constipation
Ear problems
Headache
Infections
Nausea
Pink eye
Rashes
Sinus infection
Sore throat
Sunburn
UTI

Behavioral health

Addictions
Anxiety
Depression
Relationship issues
Grief and loss
Trauma and PTSD
Stress management

What you need to know

Doctor On Demand is simple to use. Here are some basic things to know:

- Doctor On Demand is a great option when your child isn't feeling well outside business hours, but dependents will need a parent present during the visit.
- The average wait time to connect with a physician is less than 10 minutes.
- You can use Doctor On Demand as often as you need to.
- Doctor On Demand helps you manage costs, with virtual medical visits generally less expensive than in-person visits. Your visit cost is provided up front before you book your appointment. Costs for behavioral health visits vary depending on the type of care.
- This is more than a nurse advice line. With Doctor On Demand, a doctor can diagnose, treat and prescribe medications, as necessary.
- You'll work with a Doctor On Demand physician or therapist, not your regular doctor.
- With your permission, the Doctor On Demand physician will share your treatment information with your regular doctor.

Visit **doctorondemand.com/regence-id** to register today. You'll want to create your online account in advance so when you need care, you'll already be set up.

Doctor On Demand is a separate company that provides telehealth services for Regence members.

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is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho
1211 West Myrtle Street, Suite 200 | Boise, ID 83702

REG-732142-21/12-ID

Dental

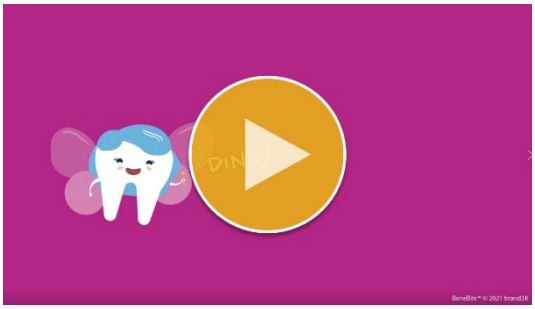
OUR PLANS

Delta Dental of Idaho PPO Plan

Willamette HMO Dental Plan

Northwest Dental Benefits PPO Plan

Click to play video



Why sign up for Dental coverage?

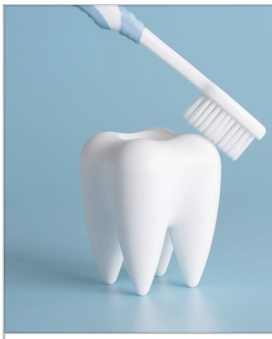
It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings, and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns, and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

You always pay the deductible and copayment ($). The coinsurance (%) shows what the **plan** pays after the deductible.

	**Delta Dental of Idaho PPO Plan**	**Willamette HMO Dental Plan**	**Northwest Dental Benefits PPO Plan**
	Delta Dental members can visit any licensed dentist for dental care, but you can save the most by choosing a dentist in the Delta Dental PPO network.	Willamette Dental is an HMO managed-care plan. You must visit a Willamette facility for services.	With NWDB, you are required to use the Premier Provider Network. Out-of-network benefits are offered but with specific limitations.
Benefits	**In-Network Benefits**	**In-Network Benefits**	**In-Network Benefits**
Annual Deductible	$50 per individual $150 per family	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum	$1,250	Unlimited	$2,500
Diagnostic & Preventive (exams, cleanings, x-rays, sealants, fluoride)	100%	100% after copay (varies by service; see fee schedule on next pages)	100% after copay (varies by service; see fee schedule on next pages)
Basic Services (fillings, root canals, periodontics, oral surgery)	80% after deductible	100% after copay (varies by service; see fee schedule on next pages)	100% after copay (varies by service; see fee schedule on next pages)
Major Services (dentures, implants, bridges, crowns)	50% after deductible	100% after copay (varies by service; see fee schedule on next pages)	100% after copay (varies by service; see fee schedule on next pages)
Orthodontia	Not covered	Pre-orthodontia treatment: $150 copay; Comprehensive treatment: $2,800 copay; (see contract for limitations) Children: Covered Adults: Covered	$2,500 lifetime maximum (see contract for limitations) Children: Covered Adults: Covered

DELTA DENTAL Willamette Dental Group NORTHWEST DENTAL BENEFITS

Summary of Benefits

Willamette Dental

Bonner County – ID29– 10/1/2025

COVERED BENEFITS	COPAYS
Annual maximum	No annual maximum*
Deductible	No deductible
General & ortho office visit	You pay $15 per visit
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & emergency exams	Covered with the office visit copay
X-rays	Covered with the office visit copay
Teeth cleaning	Covered with the office visit copay
Fluoride treatment	Covered with the office visit copay
Sealants (per tooth)	Covered with the office visit copay
Head and neck cancer screening	Covered with the office visit copay
Oral hygiene instruction	Covered with the office visit copay
Periodontal charting	Covered with the office visit copay
Periodontal evaluation	Covered with the office visit copay
RESTORATIVE DENTISTRY	
Fillings	Covered with the office visit copay
Porcelain-metal crown	You pay a $225 copay**
PROSTHODONTICS	
Complete upper or lower denture	You pay a $350 copay**
Bridge (per tooth)	You pay a $225 copay**
ENDODONTICS & PERIODONTICS	
Root canal therapy - anterior	You pay a $85 copay
Root canal therapy - bicuspid	You pay a $110 copay
Root canal therapy - molar	You pay a $140 copay
Osseous surgery (per quadrant)	You pay a $150 copay
Root planing (per quadrant)	You pay a $60 copay
ORAL SURGERY	
Routine extraction (single tooth)	Covered with the office visit copay
Surgical extraction	You pay a $80 copay
ORTHODONTIA TREATMENT	
Pre-orthodontia treatment	You pay a $150 copay***
Comprehensive orthodontia treatment	You pay a $2,800 copay
DENTAL IMPLANTS	
Dental implant surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local anesthesia	Covered with the office visit copay
Dental lab fees	Covered with the office visit copay
Nitrous Oxide	You pay a $40 copay
Specialty office visit	You pay $30 per visit
Out of area emergency care reimbursement	You pay charges in excess of $100

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

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

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
028-ID(3/25)

Exclusions and Limitations

Willamette Dental

This is only a summary. The certificate of coverage contains a complete description of the limitations and exclusions.

EXCLUSIONS

- Bone grafting.
- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage.
- Cone beam CT X-rays and tomographic surveys.
- Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
- A dental implant surgically placed prior to the member's effective date of coverage that has not received final restoration or a dental implant for treatment of a primary or transitional dentition.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Eposteal, transosteal, endodontic endosseous, or mini dental implants.
- Exams or consultations needed solely in connection with a service not listed as covered.
- Experimental or investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia, moderate sedation and deep sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
- Maintenance, repair, replacement, or completion of an existing implant started or placed by a non-participating provider without a referral from a Willamette Dental Group, P.C. provider.
- Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's effective date of coverage.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group. P.C. dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services not listed as covered in the contract.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

LIMITATIONS

- If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group, P.C. dentist is covered.
- Services listed in the contract, which are provided to correct congenital are covered for dependent children if dental necessity has been established.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group, P.C. dentist.
- The retreatment of root canal therapy performed by a Willamette Dental Group. P.C. dentist will be covered as part of the initial treatment for the first 24 months. The retreatment of root canal therapy performed by a non-participating provider will be subject to the applicable copays.
- The services provided by a dentist in a hospital setting must meet the requirements in the contract to be covered.
- The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.

Administrative Office: 6950 NE Campus Way, Hillsboro, OR 97124
028-ID(3/25)

NORTHWEST DENTAL BENEFITS

2025

Up to
$2,500
ORTHODONTIA BENEFIT

$2,500
ANNUAL MAXIMUM

$0
DEDUCTIBLES & OFFICE VISIT FEES

SUPERIOR
ORTHODONTIA COVERAGE

No age limit

Use towards traditional braces or Invisalign® treatment

CONVENIENT
VISITS & CARE

Providers authorized to approve same-day treatment

No need for traditional preauthorizations to save you time

Sample Benefits	Your Copay*
PREVENTATIVE SERVICES	
Routine Exams	$0
Cleanings *(2 per 12 months)*	$0
Bitewing X-Rays *(1 per 12 months)*	$0
Full Mouth X-Rays	$0
Fluoride	$0
Sealants	$0
BASIC SERVICES	
Fillings	$35
Simple Extractions	$35
Oral Surgery *(Surgical extractions/ impactions)*	$60
Periodontics	$50/ quad $30/ maintenance
Emergency Pain	$0
MAJOR SERVICES	
Root Canals	$250 - $400
Crowns	$350 - $400
Core Buildup	$50
Dentures	$750
Implants *(6 month waiting period)*	$850
Wisdom Teeth Removal	$100 - $135

*This is a brief comparison only. Copays associated with fees deducted from Annual Maximum. For detailed information, please see complete Benefit Summary and/or contract. If discrepancies exist, the contract shall prevail.

LEADING
BENEFITS & MAXIMUMS

Plans cover commonly excluded services

Double the Annual Maximum of traditional plans, on average

PREMIER
LOCAL PROVIDERS

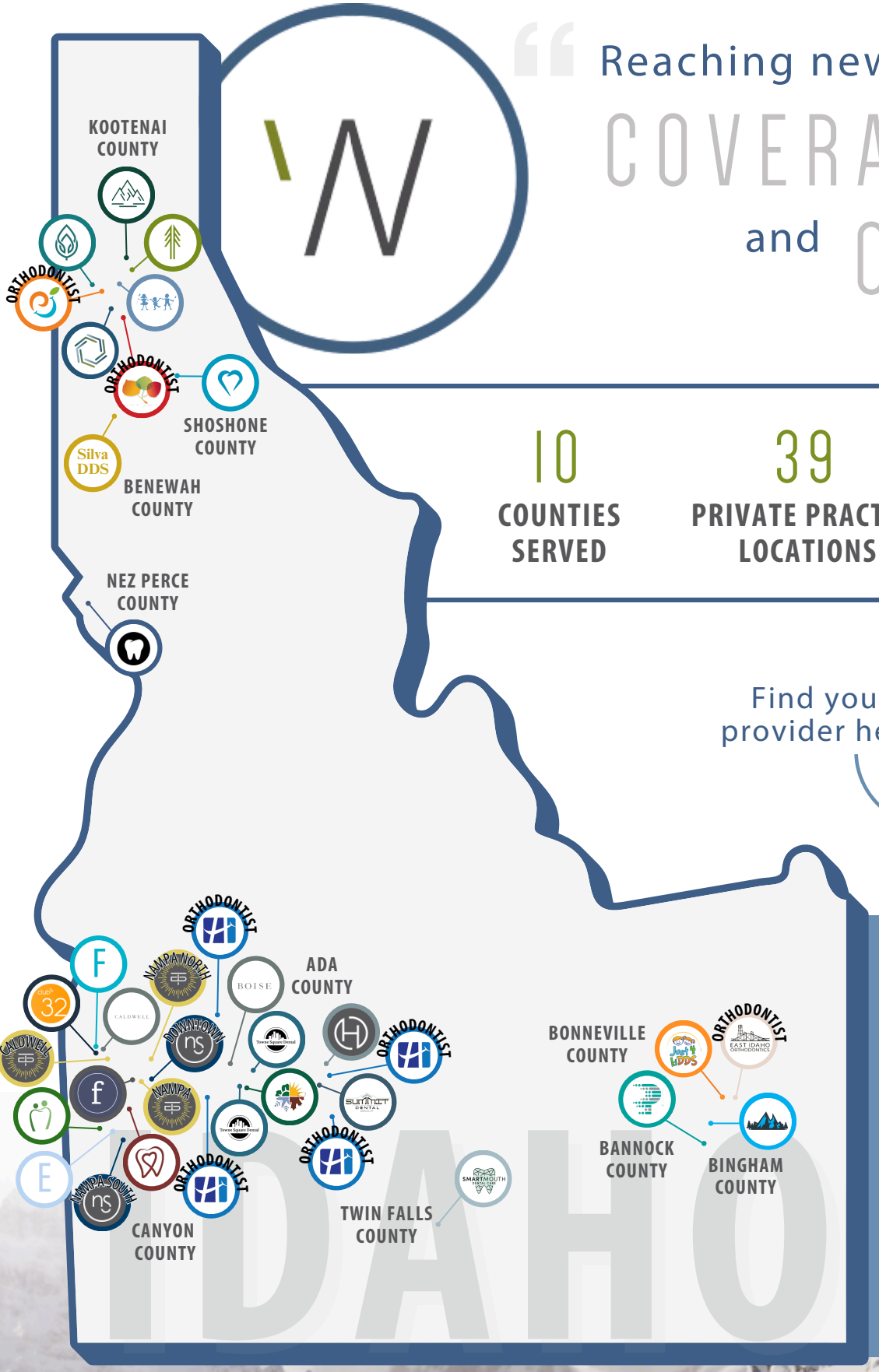
60+ dentists and orthodontists, including general and pediatric dentists

39 private-practice locations across Idaho ready to serve you

@NorthwestDentalBenefits

2025 IDAHO NETWORK OFFICES

"Reaching new heights in COVERAGE and CARE"



10	39	68
COUNTIES SERVED	PRIVATE PRACTICE LOCATIONS	LOCAL PROVIDERS

Find your provider here

NWDB GIVES BACK

Each quarter, NWDB donates a portion of premiums to three local causes. Since 2020, NWDB has donated over $30,000 to local organizations, nominated and voted on by our Members and Groups. Learn more at NorthwestDentalBenefits.com.

Vision

OUR PLAN

Vision Service Plan (VSP) Choice Plan

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

Click to play video

Vision Service Plan (VSP) Choice Plan

Your vision checkup is fully covered after your exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

Benefits	In-Network Benefits
Copay – Exam	$10 copay then 100%
Copay - Materials	$25 copay
Lenses	
Single Vision	Basic lens covered in full (copay applies)
Bifocal	Basic lens covered in full (copay applies)
Trifocal	Basic lens covered in full (copay applies)
LightCare	Uses both lens and frame benefit
Frames	Up to $130 allowance; Featured frame brands, including bebe, Calvin Klein, Cole Haan, Dragon, Flexon, Longchamp, Nike, and more are covered up to the enhanced featured frame allowance of $180; plus a 20% discount from the remaining balance
Contacts	Fitting & eval exam: up to $60 copay; Elective contacts: up to $130 allowance (copay waived; instead of eyeglasses)
Benefit Frequency	
Contacts, Lenses, Exam	1 x every 12 months from last date of service
Frames	1 x every 24 months from last date of service

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and BONNER COUNTY. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $50 to spend on Featured Frame Brands†

bebe Calvin Klein COLE HAAN
DRAGON FLEXON LONGCHAMP PARIS
and more

Up to 40% Savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With private practice doctors, Visionworks®, and Eyemart Express retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Get more at preferred in-network doctor locations

private practice doctors · Visionworks · EYEMART EXPRESS FAMILY OF STORES

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through BONNER COUNTY.

Provider Network:
VSP Choice
Effective Date:
10/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME+	• $180 Featured Frame Brands allowance • $180 Visionworks or Eyemart Express frame allowance on any frame • $130 frame allowance • 20% savings on the amount over your allowance • $130 Walmart/Sam's Club frame allowance • $70 Costco frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE™+	• $130 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$25	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor.

Health savings account (HSA)

Click to play video

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the HDHP Medical Plan
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare
3. Not a tax dependent
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses

Flores
Better Benefits Experience.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the Flores HSA works:

- For those enrolling in the HSA medical plan, Bonner County will contribute the following amounts to your Health Savings Account:

2025-2026 Contribution Amount Per Pay Period (24)		
Individual HSA $2,000 HSA Plan	Non-Wellness $62.50	You can earn an additional $300 upon completion of the Wellness Program
Family HSA $3,300 HSA Plan	Non-Wellness $104.16	

- You can contribute up to the limit set by the IRS each year (includes company amount)

IRS Contribution Limits	
2025	Individual: $4,300 per year; Family: $8,550 per year
2026	Individual: $4,400 per year; Family: $8,750 per year

Are you age 55 +? You can contribute an additional $1,000 per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA:

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings**. After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Any employee that does not complete the requested identity verification steps for their HSA account within 60 days of becoming eligible forfeits the Bonner County employer funding. The employee is responsible for ensuring their total annual contribution into their HSA account, including the amount contributed by Bonner County, does not exceed the annual IRS contribution maximums listed above.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-deductible savings account you can contribute to while covered by an HSA-qualified high deductible health plan. It allows you to save, invest, and use funds on a tax-free basis to realize triple tax savings!

YOUR STEPS TO TRIPLE TAX SAVINGS!

1 DECIDE IF AN HSA IS RIGHT FOR YOU

A Health Savings Account (HSA) is a tax-advantaged account that you may elect to establish whenyou enroll in a high deductible health plan (HDHP). If you're considering an HSA, you can access savings calculators and other resources to determine if it's the right plan option for you at www.flores247.com.

2 REALIZE THE TRIPLE TAX ADVANTAGE

For 2025, you can contribute up to **$4,300** if you are enrolled in single HDHP coverage, and up to **$8,550** if you are enrolled in family HDHP coverage. Individuals over the age of 55 may make an additional catch up contribution of **$1,000**. Contributions can be made through pre-tax payroll deductions. You can also invest your contributions and receive tax-free earnings. Distributions for qualified expenses are tax-free as well!

3 ENROLL AND MANAGE YOUR ACCOUNT

Contact your Human Resources Department to find out how to enroll for this benefit. Floreswill send a custom Participant ID number via mail or email to help you manage your account. Contact information can be found on the back of this flyer.

ELIGIBLE EXPENSES

- Deductible expenses
- Prescriptions
- Vision expenses (including eye exams, eyeglasses, and contact lenses)
- LASIK surgery
- Dental expenses (excluding cosmetic procedures)
- Orthodontia payments
- Over-the-counter medications and supplies
- Menstrual Care Items
- Certain insurance premiums

HSA FAQS

FREQUENTLY ASKED QUESTIONS

IS AN HSA THE SAME AS AN FSA? No. An HSA is a tax-deductible savings account that lets you save every year toward healthcare expenses. There's no use-it-or-lose-it rule, and you can grow your account through interest and investments. And it's portable, so you take it with you if you leave the company. To maintain HSA contribution eligibility, you must be enrolled in a high deductible health plan (HDHP) and cannot have any other disqualifying coverage (see IRS Publication 969).

WILL I LOSE MONEY IN MY HSA IF I DON'T SPEND IT? No. There's no use-it-or-lose-it rule with an HSA, so every dollar that goes into it becomes available for your use for eligible expenses.

WILL I HAVE A DEBIT CARD? Yes. You will receive a Flores Benefit Card that will be linked to your HSA. You can use it to pay providers when you incur eligible services.

HOW DOES AN HSA SAVE ME MONEY ON TAXES? Three ways:

1) Money goes in tax-free. You pay no tax on the money you or your employer put into your HSA, up to the IRS limits.
2) Money earns tax-free. You pay no tax on interest and investment returns earned in your HSA.
3) You pay no tax on HSA money when you use it to pay eligible healthcare expenses.

HOW WILL I ACCESS INFORMATION ON MY ACCOUNT?
You will access account information and manage your account on our website, flores247.com.

WHEN IS MY HSA FUNDED? You or your employer can add money to your HSA at any time during the year. There's no enrollment period. Most employees fund their HSAs through payroll deductions.

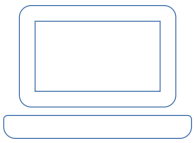
WHO OWNS MY HSA? You own it outright. If you leave the company for any reason, you own the account, including any interest earned.

CAN I CHANGE MY CONTRIBUTION AMOUNT DURING THE PLAN YEAR? Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.

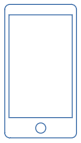
IS TAX REPORTING REQUIRED FOR AN HSA? Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize this form. We recommend you maintain records of itemized receipts for your purchases in case you are audited by the IRS.

HOW DO I ACCESS THE FUNDS IN MY HSA? Your HSA is similar to a checking account. You are responsible for ensuring money is spent on qualified purchases only and maintaining records. Payments can be made via check, online bill-pay, your Flores Benefit Card, or you can reimburse yourself if you pay out-of-pocket for an expense.

HOW DO I OBTAIN MY ACCOUNT DETAILS?



WEBSITE
Visit www.flores247.com and log in using Participant ID or User Name and password



MOBILE APP
Download the Flores Mobile smartphone app, available for Apple or Android devices

PID & PASSWORD ASSISTANCE
Dial 800.840.7684

LEARN MORE:

For more information on how to use your funds, manage your expenditures, using Bill Pay, reordering a Flores Benefit Debit Card or help in determining if an expense is qualified, please visit www.flores247.com or call us at 800.532.3327.

Flores
Better Benefits Experience.

Revised 08/2024

CUSTOMER SERVICE 1.800.532.3327

Flores
Better Benefits Experience.

Employee FAQ:

Health Savings Accounts

What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

Funds contributed to an HSA are triple-tax-advantaged.

1. **Money goes in tax-free.** Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited into your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.

2. **Money comes out tax-free.** Eligible healthcare purchases can be made tax-free when you use your HSA. Purchases can be made directly from your HSA account, either by using your benefits debit card, ACH, online bill-pay, or check – or, you can pay out-of-pocket and then reimburse yourself from your HSA.

3. **Earn interest, tax-free.** The interest on HSA funds grows on a tax-free basis. And, unlike most savings accounts, interest earned on an HSA is not considered taxable income when the funds are used for eligible medical expenses.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, vision, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

Am I eligible to participate?

In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.

What is a high-deductible health plan?

A HDHP is a health insurance plan with deductible amounts that are greater than **$1,650** for individual or **$3,300** for family coverage and have an out-of-pocket maximum that does not exceed **$8,300** for individual or **$16,600** for family coverage.

How do I contribute money to my HSA?

Payroll deduction is most likely offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

Can I change my contributions to my HSA during the year?

Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed **$4,300** for singles or **$8,550** for families in **2025**. Individuals aged 55 and over may make an additional $1,000 catch-up contributions.

Do I have to spend all my contributions by the end of the plan year?

No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-deferred.

What happens if my employment is terminated?

HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.

How do I access the funds in my HSA?

Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your HSA.

Can I withdraw the money for non-healthcare purchases?

Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll be subject to your ordinary income tax, in addition to 20% tax penalty. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.

Can I roll over or transfer funds from my HSA or Medical Savings Account (or Archer MSA) into an HSA?

Yes. Pre-existing HSA funds or MSA monies may be rolled into an HSA and will continue their tax-free status.

Can I control how the funds are invested?

Yes. Once your HSA cash account balance reaches the minimum amount required by the custodian, you can transfer funds to an HSA investment account. You can choose from a selection of mutual funds and setup and allocation model for future transfers like you would for a 401k plan.

Can I transfer funds between the cash and investment accounts?

Yes. You can transfer money between your HSA cash and HSA investment account at any time.

For more information, call 800.532.3327

Flores
Better Benefits Experience.

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HRA: Health reimbursement arrangement

Are you eligible?

You are eligible for the HRA if you are enrolled in the Regence PPO plan.

Can I have both an HRA and an FSA?

Yes! You can have both an HRA and a healthcare flexible spending account (FSA) at the same time, but you can't be reimbursed from both accounts for the same expense. The HRA is typically used first until the account is depleted.

Your "allowance" for healthcare expenses

Healthcare can be expensive. That's why Bonner County provides eligible participants with an HRA to help pay your medical expenses. The HRA is administered by Veba.

💰 Earn a $300 Wellness Bonus!

Here's how it works:

- Complete all Wellworks activities (shown on page 61) and receive a one-time $300 incentive deposit added to your HRA account. It's our way of rewarding you for investing in your health!
- You are eligible if you are enrolled in the Regence $1,500 PPO plan.
- When you have a healthcare expense, you can use your HRA debit card or submit a request for reimbursement with a receipt or supporting documents.

Reasons to love an HRA:

1. **It's 100% employer-funded.** All contributions are made by Bonner County. In fact, the rules prohibit employee contributions.
2. **It's tax-free.** HRA reimbursements are excluded from your gross income, so they are 100% tax-free.
3. **No "use it or lose it."** As long as you stay with Bonner County, unused money rolls over to use in future years.

HRAveba®

HRA Basics

Health Reimbursement Arrangement

An HRA is a **tax-free account** that **puts you in control** of your family's healthcare spending[1]. It's easy to use, and it's a smart way to save up for medical bills, including retiree insurance premiums. Plus, you never pay any taxes on the money going in or coming out. That's the **best tax advantage** there is—even better than tax-deferred 457, 403(b), and 401(k) plans!

- Pay no income or FICA taxes
- Choose your investments
- Get your money fast
- No use-or-lose or carryover limits

> *I didn't have enough money to purchase my contact lenses and my prescription medication. I was able to use my HRA money. What a relief!*
>
> HRA Participant

How It Works

1. Your employer **sends tax-free money** to your HRA[2]. Often, these funds would have otherwise been paid to you as taxable income. Your employer might also contribute funds in place of some other tax-free employee benefit.

2. You choose how you want to **invest your HRA funds** using the available fund lineup.

3. Depending on your plan[3], you can **use your money right away or save it up for later**, such as during retirement.

4. If you pass away, your HRA can transfer to your surviving spouse, children, or other survivors. Most other HRA plans can't offer this.

[1] Your HRA covers you, your spouse, and dependents, including your adult children through the end of the calendar year in which they turn age 26. [2] IRS rules require all eligible employees to participate (no individual elections). [3] Your HRA may be subject to post-separation benefits only or other limitations depending on your employer's plan design or any limited HRA coverage elections you may make.

How It Helps

Are you struggling to cope with the cost of **doctor visits, prescriptions, new glasses or contacts, or braces for the kids?** Will you and your spouse be able to afford medical premiums up to **$1,000 or more per month** if you want to retire before age 65?

> *This plan helped me retire a few years early and pay insurance premiums until Medicare kicks in.*
>
> HRA Participant

Many participants use their HRAs to reimburse **retiree insurance premiums** and the cost of medical care items and services they wouldn't be able to afford otherwise, like **power chairs, hearing aids, expensive vision and dental care, and emergency medical bills**.

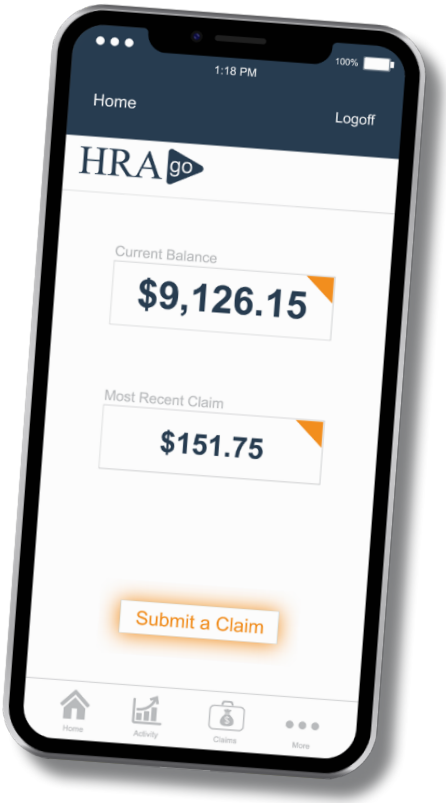
Using Your HRA

Managing and using your HRA is now easier than ever!

- Fast online and mobile claims
- Handy mobile app (HRAgo®)
- Free debit card
- Secure e-statements

Ready to file a claim? Log in online and click **Claims**, or use **HRAgo** and do it "on the go." With HRAgo, you can quickly snap pics of supporting documentation and submit claims right from your mobile device. We'll process your claim in about five to seven business days.

Are you a retiree? We can automatically reimburse your monthly insurance premiums, including Medicare premiums. Log in online and, click **Claims**. Then, click the **Set up an Automatic Premium Reimbursement** button.



Download on the App Store GET IT ON Google Play

More Information
HRAveba.org

Ask Questions
1-888-659-8828

HRAveba.

The HRA VEBA Plan is a group health plan. Plan administrative fees are $1.50 (if claims-eligible) or $0.75 (if not claims eligible) per month, plus an annualized asset-based fee of about 1.00%. The monthly fee is waived if your account balance is more than $5,000. In addition, a 0.25% asset-based fee discount applies to any portion of your account balance in excess of $10,000. Please refer to the HRA VEBA Plan Summary for more details.

Healthcare flexible spending account (FSA)

Click to play video

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in the high deductible health plan, you can only participate in the limited-purpose FSA for dental and vision expenses.

Find out more

- PeakOneAdmin.com
- Eligible Expenses
- Ineligible Expenses

PEAKONE administration

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the works:

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to $3,300, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $660 to use the following year. Any additional remaining balance will be forfeited.

Potential tax savings:

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

$60,000 annual pay, contributing $1,700 to FSA

$374	$130	$504
22% income tax savings	7.65% FICA tax savings	Total FSA tax savings

$120,000 annual pay, contributing $3,300 to FSA

$792	$252	$1044
24% income tax savings	7.65% FICA tax savings	Total FSA tax savings

Healthcare FSA

Do you want to save 30% on health-related expenses this year? Enrolling in a healthcare flexible spending account (FSA) can save you up to $900 a year.

What is a healthcare FSA?

A healthcare FSA is an account that lets you set aside money before taxes to pay for many medical expenses for yourself, your spouse, or eligible dependents.

What can it be used for?

Eligible expenses include things like insurance copayments and deductibles, prescription drugs, vision and dental expenses.

How does it work?

1. During open enrollment, sign up for a healthcare FSA.
2. Choose how much money you'd like to set aside for medical expenses.
3. The amount you've chosen is divided equally and deducted from your paycheck over the course of the year.
4. When paying for eligible expenses, you can use your Peak One Debit Card to pay direct or use your personal funds and get reimbursed.

When can I use it?

Conveniently, the total amount you've chosen to put in your FSA is available to start spending on the first day of your plan.

Helpful Tips

Plan ahead to maximize your healthcare FSA and use all your funds each year.

- Review what you paid for health-related expenses last year – are there any reoccurring items?
- Think about the upcoming year – does anyone in your family need orthodontia or vision care? Are you thinking of having a child?
- Use the information to figure out how much you'd like to have in your FSA.

Did You Know?

You can use your FSA for:

- Medical procedures and surgeries
- Exercise and wellness expenses
- Family planning and care
- Many prescription drugs, vitamins, and probiotics

Sign up for a healthcare FSA and start saving today!

www.PeakOneAdmin.com

3903 E Primrose Lane, Suite 102
Post Falls, ID 83854
866.315.1777

PEAK ONE administration

Paying for daycare? Make it tax-free!

Click to play video

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Peak.

Here's how the Peak plan works:

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Sign up for a FSA and DCFSA and start saving today!

www.PeakOneAdmin.com

3903 E Primrose Lane, Suite 102
Post Falls, ID 83854
866.315.1777

PEAK ONE administration

Employee FAQ

Dependent Care FSA (DCFSA)

What is a dependent care FSA (DCFSA)?

A dependent care FSA (DCFSA) is an account that lets you set aside money before taxes to pay care providers who watch your children and eligible dependents while you're at work.

Why should I enroll in a DCFSA?

The money you put into a DCFSA is set aside from your paycheck before taxes. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $1,500 per year on dependent care expenses!

How do I contribute money to my dependent care FSA?

The amount you elect as your annual contribution will be divided by the number of paychecks for the year. This pay period amount will be deducted from each paycheck before taxes.

You can then use the money in your account to pay for eligible dependent care expenses throughout the plan year.

Who qualifies as a dependent?

Dependents are children under age 13, that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

When can I use my dependent care FSA?

You can use funds from your dependent care FSA under the following conditions:

- To care for your qualified dependent.
- To allow you (and your spouse if filing jointly) to work or look for work.

Dependent care FSA funds can cover costs for before or after school care for children aged 12 and younger, custodial care for dependent adults, licensed daycare centers, nanny or au pair services, nursery schools or preschools, late pickup fees, and summer or holiday day camps.

What doesn't qualify?

There are certain expenses you cannot pay for using your dependent care FSA. These include expenses from a prior plan year, expenses for non-disabled children aged 13 and older, educational expenses (including kindergarten or private school tuition fees), food, clothing, sports lessons, field trips and entertainment, overnight camp expenses, and late payment fees for childcare.

Can I use my entire dependent care FSA election amount at the beginning of the year?

No, you will only have dependent care FSA funds as they are equally deducted each pay cycle. Funds will accumulate in your account until you either file a claim for reimbursement or you use your dependent care FSA Mastercard card.

Are there any rules about who can care for my dependents?

Yes, you cannot use funds to pay for care provided by a spouse, a person listed as a dependent on your taxes, or your child under the age of 19.

How do I use my dependent care FSA to pay for qualified expenses?

If your care provider accepts Mastercard, you can use your Peak One Administration dependent care FSA debit card for eligible expenses. You'll need to wait until you have accumulated enough funds in your account to use the debit card, so make sure to check your balance on the WealthCare Portal or Peak1

Admin Mobile App.

You can use personal funds and then reimburse yourself with funds from your dependent care FSA by submitting an online claim through the WealthCare Portal or via the Peak1 Admin Mobile App. You'll need to provide photos of receipts when you submit a claim for reimbursement. Reimbursement won't be processed until you have enough funds in your account.

What happens if I don't spend all my dependent care FSA funds by the end of the plan year?

Any unused funds that are in your account at the end of the year will be forfeited, which means you will lose that money. Plan carefully so that you use all the money in your dependent care FSA by the end of the plan year.

Can I change my election amount mid-year?

You can only enroll or change your election amount mid- year if you have a special event like a birth, death or assume care for an elderly person. If your care provider changes rates or fees, or your child turns 13 you may also adjust the amount you set aside.

What happens to my account if I lose my job or quit?

Unfortunately, participation in your dependent care FSA is discontinued as of your last day of employment. Expenses for services rendered after your termination date are not eligible for reimbursement.

Questions?

Contact membercare@peakoneadmin.com.

Life & Disability

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

Bonner County-provided life and AD&D insurance

What's guaranteed issue?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status to qualify for the requested amount of coverage.

A note about taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by Bonner County.

Lincoln Life & AD&D

Employee	1 x base annual salary up to $100,000
Spouse	$1,000
Children	$100 up to $1,000 dependent on age

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

Lincoln Financial®

Long-term disability insurance

Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-term disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

Bonner County pays the cost of this coverage.

Lincoln LTD Benefits

Amount	60% of earnings, up to a monthly maximum of $5,000
Begins	after 90 days of disability
Duration	to age 65 or social security normal retirement age

Lincoln Financial®

Voluntary Plans

OUR VOLUNTARY PLANS

- Voluntary Life and AD&D
- Voluntary Short-term Disability
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

Bonner County offers plans to help:

- provide income for survivors
- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

Voluntary life and AD&D insurance

Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit evidence of insurability with additional information about your health for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary life and AD&D insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or children if you purchase coverage for yourself.

Lincoln Voluntary Life & AD&D

Employee	3 x the employee's annual salary up to $250,000. Guaranteed issue of $150,000.
Spouse	1.5 x the employee's annual salary or 50% of the employee's benefit amount up to $125,000. Guaranteed issue of $25,000.
Children	> 14 days $10,000

Lincoln Financial®

Short-term disability insurance

Expect the unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Voluntary STD Benefits

Short-term disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability.

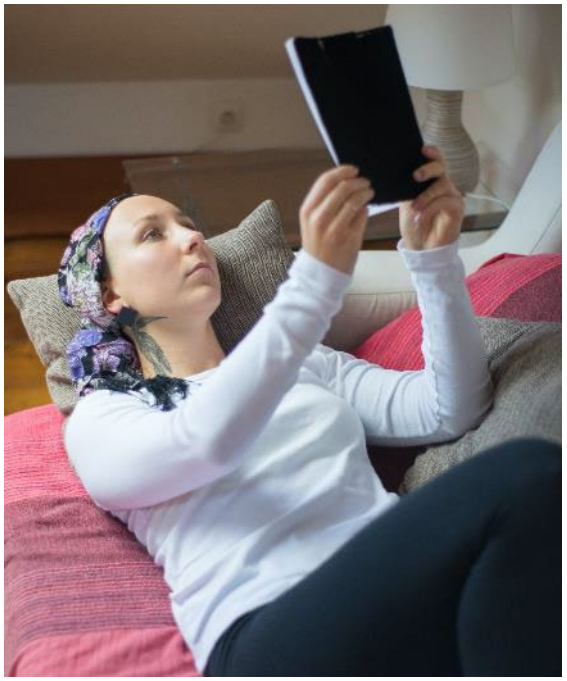
You pay the cost of this coverage.

Lincoln STD Benefits

Amount	60% of earnings, up to a weekly maximum of $1,000
Begins	after 7 of disability due to accident or 7 of disability due to sickness or maternity
Duration	12 weeks

Lincoln Financial®

Voluntary health-related plans



Things to consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Aflac®

Accident Insurance

Accident insurance from Aflac helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest X-ray.

Critical Illness Insurance

Critical illness insurance from Aflac can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest X-ray.

Hospital Indemnity Insurance

Hospital indemnity insurance from Aflac can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Group Accident Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Initial Accident Treatment Category- Mid	Employee	Spouse	Child
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$150	$150	$150
ER/Urgent Care with X-Ray	$200	$200	$200
Doctor's Office	$75	$75	$75
Doctor's Office with X-Ray	$100	$100	$100
Ambulance - once per day, within 90 days of the accident			
Maximum number of payments per covered accident: No Maximum			
Ground	$300	$300	$300
Air	$900	$900	$900
Major Diagnostic Testing - within six months of the accident Maximum number of diagnostic tests per covered accident: 1	$150	$150	$150
Concussion - once per accident, within six months of the accident	$350	$350	$350
Traumatic Brain Injury - once per accident, within six months of the accident	$3,500	$3,500	$3,500
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a	$7,500	$7,500	$7,500

Fracture - once per covered accident, within 90 days of the accident

Fracture Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip/Thigh	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Vertebrae/Sternum	$5,400	$5,400	$5,400	$2,700	$2,700	$2,700
Pelvis	$4,800	$4,800	$4,800	$2,400	$2,400	$2,400
Skull (Depressed)	$4,500	$4,500	$4,500	$2,250	$2,250	$2,250
Leg	$3,600	$3,600	$3,600	$1,800	$1,800	$1,800
Forearm/Hand/Wrist	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Foot/Ankle/Kneecap	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Shoulder Blade/Collar Bone	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Lower Jaw	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Skull (Simple)	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050
Upper Arm/Upper Jaw	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050

Hospitalization Category - Mid	Employee	Spouse	Child
Hospital Admission (per confinement) - once per accident, within six months of the accident Maximum number of admissions per covered accident: 1	$900	$900	$900
Hospital Confinement (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 365	$225	$225	$225
Hospital Intensive Care (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 30	$300	$300	$300
Intermediate Intensive Care Step-Down Unit (per day) - within six months of the accident Maximum days of confinement per covered accident: 30	$150	$150	$150
Family Member Lodging (per day) - within six months of the accident Maximum days of lodging per covered accident: 30 Minimum Required Distance (miles): 100	$150	$150	$150

Wellness Rider - Mid	Employee	Spouse	Child
Amount paid will be based on the certificate year in which the wellness test was performed: Maximum number of payments per calendar year, per insured: 1			
Year 1 - Once per calendar year	$25	$25	$25
Year 2 - 4 Once per calendar year	$50	$50	$50
Year 5 + Once per calendar year	$75	$75	$75

Premiums per paycheck

Coverage	Premium
Employee	$5.74
Employee and Spouse	$9.99
Employee and Child(ren)	$13.24
Family	$17.49

Group Critical Illness Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Base Benefits	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Disease	100%
Major Organ Failure*	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Type I Diabetes	100%

*25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant

Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$1000 per calendar year
Metastatic Cancer	25%

Health Screening Benefit	
Health Screening (payable for employee and spouse only)	$50
Health Screening (payable for dependent children)	100% of the Health Screening Amount
Payable per calendar year	1

Childhood Conditions Rider	
Cystic Fibrosis, Cerebral Palsy, Cleft Lip or Cleft Palate, Down Syndrome, Phenylalanine Hydroxylase Deficiency Disease (PKU), Spina Bifida	50% of employee benefit
Autism Spectrum Disorder	$3,000

Occupational Disease Rider	
Occupational HIV (maximum of one payment)	100%
Occupational Hepatitis B or C (maximum of one payment per disease)	10%

Progressive Diseases Rider	
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%
Amyotrophic Lateral Sclerosis (ALS)	100%
Sustained Multiple Sclerosis (MS)	100%
Chronic Obstructive Pulmonary Disease (COPD)	25%
Crohn's Disease	25%

Group Critical Illness Insurance

Premium Rates

Employee premiums per paycheck

Age	$10,000	$20,000	$30,000
18-29	$2.73	$5.46	$8.19
30-39	$5.05	$10.10	$15.15
40-49	$9.46	$18.93	$28.39
50-59	$16.26	$32.52	$48.78
60+	$28.71	$57.42	$86.12

Spouse premiums per paycheck

Age	$5,000	$10,000	$15,000
18-29	$1.37	$2.73	$4.10
30-39	$2.53	$5.05	$7.58
40-49	$4.73	$9.46	$14.20
50-59	$8.13	$16.26	$24.39
60+	$14.36	$28.71	$43.06

Group Hospital Indemnity Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Hospitalization Benefits - Mid	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	**$1,000**
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	**$150**
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$150**
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$75**

Health Screening Benefit	
Health Screening Benefit Payable once per calendar year per insured.	**$50**

Group Hospital Indemnity Insurance

Premium Rates

Premiums per paycheck	
Coverage	**Premium**
Employee	$10.05
Employee and Spouse	$20.24
Employee and Child(ren)	$16.10
Family	$26.29

Nearing 65? Get to know Medicare

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Important deadlines ahead

Most people become eligible for Medicare at age 65. At that time, you'll need to make some important decisions about your health insurance.

But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your Bonner County-sponsored insurance. Maybe you're just not sure which options could work best for your situation.

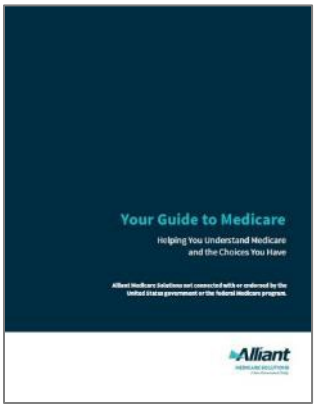
Alliant Medicare Solutions

Through Bonner County, you have access to Alliant Medicare Solutions, a free service you, your family, and your friends can use to figure out the best Medicare options for you.

How it works

- Gather your current health insurance information.
- Call Alliant Medicare Solutions at **(877) 888-0165** to talk to a licensed insurance agent about your current coverage, your Medicare options, and what might work best for your situation.
- Alliant Medicare Solutions can help you enroll in Medicare or email policy information for you to review.

Learn more



Your Guide to Medicare

Medicare 101

Social Security Planning

Wellbeing & Balance

“The key to keeping your balance is knowing when you've lost it. ”

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it’s not always easy.

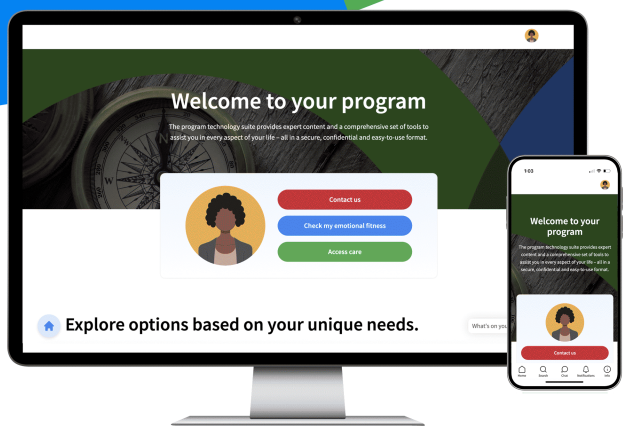
We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.
- Take time to spend with family and friends, take care of personal business, or just for yourself.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.

Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Start with Mental Health Navigator

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

supportlinc EMPLOYEE ASSISTANCE

Download the mobile app today!

1-888-881-5462

supportlinc.com
group code: **bonnercountyid**

The resources you need to meet life's challenges

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions[1] with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime online, via the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law[2]
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect offers a range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the **GuidanceNow**℠ **mobile app**. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

[1] In California, up to three sessions in six months, starting with initial contact by the employee.

[2] Services aren't included for employment law issues.

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help available 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect counselors are experienced and credentialed.

When you call the toll-free number, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow mobile app**, or call **888-628-4824**.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

LincolnFinancial.com

LCN-6441097-022824
MAP ADA 11/24 **Z07**
Order code: LTD-EAPEE-FLI001

Lincoln Financial℠

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit **GuidanceResources.com**.
  Username: LFGSupport Password: LFGSupport1
- Download the **GuidanceNow℠ mobile app**.
- Call **888-628-4824**.

Lincoln Financial℠ | ComPsych® GuidanceResources® Worldwide

Welcome to **Wellness 2025**

Bonner County is committed to employee health and wellness. All medically enrolled employees will have opportunities to participate in various wellness activities to earn an incentive. Your new program requirements are listed below.

STEP 1

Biometric With Lab Work
DEADLINE: JULY 31, 2026

STEP 2

Annual Wellness Visit with Primary Care Provider
DEADLINE: JULY 31, 2026

STEP 3

Know Your Number Assessment
DEADLINE: JULY 31, 2026

STEP 4

Tobacco Attestation/Cessation e-Learning Series
DEADLINE: JULY 31, 2026

Get started on your wellness journey.

Log into your Wellness Portal today!

Download on the App Store

GET IT ON Google Play

Forgot Your Username Or Password?

1. Go to **www.wellworksforyoulogin.com**
2. Click the link **Forgot Username** or **Forgot Password**
3. Follow the instructions to retrieve your username or reset your password
4. If issues persist, please contact Wellworks For You at **800.425.4657**

New Users:
Register on the Wellness Portal

1. Go to **www.wellworksforyoulogin.com**
2. Click the **register** link and create an account
3. Enter your Company ID: **10925**
4. Complete the registration process

Your well-being journey starts here

EARN UP TO
$25
IN GIFT CARDS

Earn rewards for healthy activities

Meet Regence Empower®, your personalized well-being experience. Guided step by step, you'll always know what to do next to reach your goals. Complete activities that help you feel your best and earn rewards along the way. To start your well-being journey, sign in at **regence.com** and select **Regence Empower**.

Get started by completing your Health Assessment. You'll receive a personalized report with recommendations just for you. The best part? When you complete your assessment, you'll earn a **$15 gift card**.

Plus, there are even more opportunities to earn rewards, **up to $25 total per year**, once you've started your well-being journey.

GIFT CARD
$5

Complete a self-guided program
Whether you're hoping to lower stress, build resiliency, quit tobacco or eat mindfully, Regence Empower has a variety of self-guided programs to help improve your health—on your terms and at your own pace.

GIFT CARD
$5

Sync your device
Make every step count. Regence Empower syncs with over 100 popular fitness devices and mobile apps—so you can easily keep track of your progress on activities like steps taken, calories burned and more.

GIFT CARD
$5

Complete a personal challenge
Looking to get more physical activity, reduce cholesterol or make healthier food choices? There are 40+ personal challenges to choose from, so you can pick the ones that are most helpful for your goals.

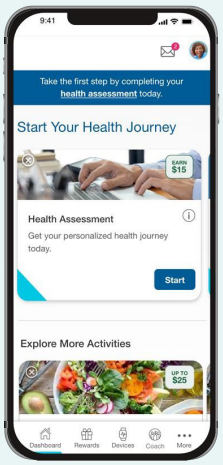
Ready to get started?

Begin your well-being journey to build healthy habits and earn rewards. Follow these three steps to get started:

1. Create your account or sign in to your account on **regence.com**

2. Scroll down and select **Go to Regence Empower**.

3. Personalize your well-being journey by completing the **Health Assessment**. It takes about 15 minutes, and you'll earn an immediate $15 reward. Keep going and earn more!



TIP: Stay engaged on the go! Download the Regence Empower app so you can easily complete activities.

Download on the App Store

GET IT ON Google Play

For wellness program reward details, visit and review the Program Summary page within Regence Empower and click the **Full Notice of Well-Being**. Call the number on the back of your member ID card if you need assistance.

Regence

Take care of yourself & save

Regence Advantages helps you and your family save on the health-related products and services you need most.

Whether you want to get fit, beat those allergies, get new glasses or more, we have discounts and offers available just for Regence members. You can even save 20% on Walgreens brand over-the-counter health and wellness products.

All you need is a **regence.com** member account to start saving.

This discount program is not insurance. It's offered along with your medical plan at no additional cost to help you take charge of your health.

Activities & fitness

Allergy relief

Alternative medicine

Financial well-being

Funeral planning

Health & wellness products

Healthy meals

Hearing aids

Pet care

Vision care

Regence

Regence BlueShield of Idaho
is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho
1602 21st Avenue | Lewiston, ID 83501

REG-ID-1347526-24/06

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Active&Fit DIRECT™

One Membership. Thousands of Ways to Stay Active and Save Money.

- 12,200+ Gyms
- 9,300+ On-Demand Videos
- 1:1 Well-Being Coaching
- Enroll Your Spouse[1]

No annual fees or long-term contracts. Switch gyms anytime.

LA Fitness · Golds Gym · Crunch · the Y · Anytime Fitness · snap fitness 24/7 · CHUZE FITNESS · blink FITNESS · Curves · EOS FITNESS

STANDARD FITNESS MEMBERSHIP
$28/mo[2]
12,200+ FITNESS CENTERS
9,300+ WORKOUT VIDEOS
Active&Fit DIRECT™ TM

Plus: 5,700+ Premium Gym Options at exercise studios, outdoor experiences, and others with 20% – 70% discounts at most locations[3]

Get Started: Regence.com/Advantages

[1] Add a spouse/domestic partner to a primary membership for additional monthly fees. Spouses/domestic partners must be 18 years or older. Fees may vary based on fitness center selection.

[2] Plus an enrollment fee and applicable taxes.

[3] Costs for premium exercise studios exceed $28/mo. and an enrollment fee will apply for each premium location selected, plus applicable taxes. Fees vary based on premium fitness studios selected.

Financial Wellness

PLANS TO HELP YOU SAVE

- WellnessPATH

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

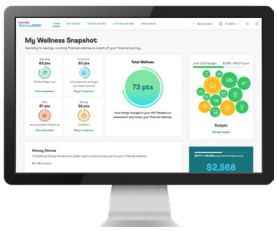
Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

Get on the path to financial wellness

Managing your everyday expenses and financial goals can be a challenge, especially if you're paying off debt, saving for retirement, or building an emergency fund.

Good news! Your personalized financial wellness tool is here to help — and it's available as part of your account with Lincoln Financial.



Lincoln WellnessPATH

A financial wellness tool that helps you improve your financial wellness.

Check out Lincoln *WellnessPATH*

Lincoln *WellnessPATH*® is an online tool that helps you manage your financial life.

Jump right in and explore the tool, or take a quick quiz to receive a wellness score and personalized steps to help you improve your financial wellness. Whether you want to create a budget, determine if you have enough life insurance, or figure out a way to save for a vacation, you can do it using Lincoln *WellnessPATH*.

See all your accounts in one place

Lincoln *WellnessPATH* allows you to securely link all your account information, including checking, savings, investment, and student loans so you have a full financial picture.

Create a simple budget

Featuring a breakdown of expenses and incomes by category, the tool makes it easy to identify spending trends and create a budget.

Set goals and track your progress

Lincoln *WellnessPATH* helps you set and track your progress toward your short- and long-term goals, motivating you to achieve what you envision.

Use resources to make informed decisions

The tool offers articles and videos featuring topics that cover different life stages and big moments — so you can learn about what's important to you.

Ready to get on the path to financial wellness?

Log in to your account at **LincolnFinancial.com/WellnessPATH** to start using the tool today! Scan the QR code to quickly take you there.

Lincoln Financial

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Lincoln is not affiliated with third party vendors provided through the *WellnessPATH*® Marketplace.

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Lincoln and its affiliates do not provide advice about the products and services offered by third party vendors. The information provided through *WellnessPATH*® Marketplace is general and educational in nature and should not be considered professional advice. Everyone's circumstances are different and before making a financial wellness decision, an appropriate professional should be consulted.

WellnessPATH® Marketplace will offer links to third-party websites that are not part of Lincoln's websites ("Sites"). Lincoln does not own, control, or endorse the content or products and services available through these third party websites. Lincoln does not assume any responsibility for any losses or damages in connection with the security, privacy practices, or content of any third party websites. These third party websites may have privacy and security policies that differ from our Sites.

LincolnFinancial.com

LCN-7653257-021925
POD 2/25 **Z04**
Order code: FWL-WEPTH-FLI001

Important Plan Information

In this section, you'll find important plan information, including:

- Your medical, dental, and vision benefit contributions for the 2025-2026 plan year
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

Your benefit costs

The total amount you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Employee Cost Per Paycheck	Employee	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
Regence Blue Shield					
PPO Base	$74.66	$160.37	$105.94	$138.54	$212.54
PPO Wellness	$43.52	$116.98	$70.33	$98.94	$161.71
HSA Base	$57.18	$115.15	$76.08	$98.95	$154.12
HSA Wellness	$28.07	$75.49	$43.52	$62.94	$107.20
Delta Dental of Idaho					
	$3.50	$7.00	$7.00	$7.00	$11.50
Willamette Dental Group					
	$4.55	$7.14	$16.98	$16.98	$39.09
Northwest Dental Benefits					
	$5.55	$7.46	$16.00	$28.84	$31.68
VSP					
	$0	$2.92	$3.33	$3.33	$7.07

WORKING SPOUSE PREMIUM SURCHARGE

If your spouse has group health coverage available through his/her employer and chooses to enroll in the Boner County medical plan, a Working Spouse Premium Surcharge of $75 per month will apply.

Plan Contacts

If you need to reach out to our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/ Group #
Medical/Pharmacy	Regence of Idaho	(866) 240-9580	regence.com	10065016
Dental	Delta Dental of Idaho	(208) 489-3580	deltadentalid.com	1464
Dental	Willamette Dental Group	(855) 433-6825	willamettedental.com	ID29
Dental	Northwest Dental Benefits	(208) 618-6932	northwestdentalbenefits.com	9130
Vision	VSP Vision Care	(800) 877-7195	vsp.com	TBD
Life/AD&D/LTD Voluntary STD	Lincoln	(877) 275-5462	LincolnFinancial.com	1283954
Accident/Critical Illness/ Hospital Indemnity	Aflac	(800) 433-3036	aflac.com	
Employee Assistance Program	CuraLinc Employee Connect	(888) 881-5462 (888) 628-4824	supportlinc.com guidanceresources.com	
HSA Administration	Flores & Associates	(800) 532-3327	flores-associates.com	
FSA/DCFSA/Cobra	Peak One	(866) 315-1777	peakoneadmin.com	
HRA Administration	Gallagher	(509) 818-3128	ajg.com	
Wellness Program	Wellworks	(800) 425-4657	wellworksforyoulogin.com	
Public Employee Retirement System of Idaho	PERSI	(800) 451-8228	www.persi.Idaho.gov	
Benefit Consultant	Shannon Mayfield	(208) 449-1001	shannon@idahosummitinsurance.com	

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Important plan information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this booklet:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice Regarding Wellness Program:** Describes voluntary nature of wellness program that includes biometrics and/or a Health Risk Assessment (HRA)
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills.

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

ANNUAL NOTICES

Medicare Part D Notice

Important Notice from Bonner County 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 Bonner County 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. Bonner County has determined that the prescription drug coverage offered by the Regence BlueShield of Idaho Classic PPO Plan and HSA Healthplan 3.0 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 Bonner County coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Regence BlueShield of Idaho Classic PPO Plan and HSA Healthplan 3.0 is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Bonner County prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Bonner County 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 or call Regence BlueShield of Idaho at (888) 675-6570. 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 Bonner County 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	10/01/2025
Name of Entity:	Bonner County
Contact-Position/Office:	Kevin Rothenberger
Address:	521 S Division Ave, Suite 202, Sandpoint, ID 83864
Phone Number:	(208) 255-3630 Ext: 1301

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 this plan. If you would like more information on WHCRA benefits, call your plan administrator at (888) 675-6570.

Newborns' and Mothers' Health Protection Act

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). If you would like more information on maternity benefits, call your plan administrator at (888) 675-6570.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Bonner County's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Bonner County's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption date. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Bonner County's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Notice Regarding Wellness Program

Regence Empower 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 may 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 may also be asked to complete a biometric screening, which would include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. You are not required to complete an HRA or to participate in any blood tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $25 in gift cards for completing your Health Assessment and engaging in specified healthy activities. Although you are not required to complete the health assessment or participate in any activities, only employees who do so will receive up to $25 in gift cards.

The information from your health assessment 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. 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 Bonner County may use aggregate information it collects to design a program based on identified health risks in the workplace, Regence Empower 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 that may receive your personally identifiable health information is 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 Kevin Rothenberger at (208) 255-3630 Ext. 1301.

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 March 17, 2025. 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)
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
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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
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

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: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
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
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: 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
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
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
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
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
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 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
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
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 Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
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 CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
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/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 of your modified adjusted household income.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Bonner County describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Kevin Rothenberger at (208) 255-3630 Ext. 1301.

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity:	Bonner County
Contact-Position/Office:	Kevin Rothenberger
Address:	521 S Division Ave, Suite 202, Sandpoint, ID 83864
Phone Number:	(208) 255-3630 Ext: 1301

Plan documents

Important documents for our health plan and retirement plan are available in the Employee Navigator portal under the “Documents” section. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Bonner County Group Health Plan

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available in the Employee Navigator portal under the “Documents” section.

- Regence PPO $1,500 Medical Plan
- Regence HSA $2,000 Medical Plan
- Regence HSA $3,300 Medical Plan

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Bonner County Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.