2027

A GUIDE TO YOUR Benefits

JANUARY 1 – DECEMBER 31, 2027

GRAHAM

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your domestic partner (DP) and/or their children, where applicable by state law
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on your date of hire, with the exception of FSA & HSA, which will be effective the first of the month following your date of hire. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1, 2027.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, DP or child
- Lost coverage under your spouse's/DP's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact the Benefits Department within 31 days of the qualifying life event (including newborns). Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

INSIDE

ENROLLMENT

Go to grahamgroupus.bswift.com

There you will find detailed information about the plans available to you and instructions for enrolling.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

TAKE A LOOK INSIDE

Health

Medical
Virtual Visits
Prescription
Dental
Vision

Wealth

Health Savings Account (HSA)
Flexible Spending Account (FSA)
Commuter Benefits
401k Retirement
Life Insurance
Disability Insurance
Voluntary Benefits

Wellbeing

Employee Assistance Program (EAP)
Mental Health Benefits
Addiction Help
Legal Assistance
Identity Theft Protection

Perks

Employee Discounts
Medicare Guidance
Will Preparation

Resources

Graham Group Benefits Website

Benefit Spot
Important Contacts
Plan Contributions
Terminology

WELCOME!

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits.

Benefits At-a-Glance

Coverage	Carrier	Plan/Benefit
Medical	Regence Group Administrators	• HDHP $4,000 deductible • HDHP $2,000 deductible • PPO $1,500 deductible
	Kaiser Permanente (CA Only)	• HMO $250 deductible
Prescription (RGA Enrollees)	RxBenefits	• Optum Rx Formulary
Dental	DeltaCare Dental Delta Dental	• DHMO • DPPO $2,000 benefit
Vision	Ameritas	• EyeMed Network • VSP Network
Health Savings Account	HSA Bank	• Must be enrolled in HDHP plan $1,000 individual / $2,000 family annual employer contribution
Flexible Spending Account	HSA Bank	• FSA – $3,400 maximum election • Limited Purpose FSA - $3,400 maximum election • Daycare - $7,500 maximum election • Commuter Benefit $325 monthly max.
Life/AD&D	New York Life Insurance Company	• 2x salary up to $500,000
Voluntary Life/AD&D	New York Life Insurance Company	• Employee $10,000 increments up to $500,000 • Spouse $5,000 increments up to $250,000 • Child(ren) Birth to 6mos $500, 6mos+ $10,000
Voluntary Short-Term Disability	New York Life Insurance Company	• 70%, $3,000 weekly maximum
Long-Term Disability	New York Life Insurance Company	• 60%, $15,000 monthly maximum
Voluntary Benefits	New York Life Insurance Company	• Accident Insurance • Critical Illness • Hospital Indemnity
EAP	ComPsych	• 5 in-person visits
Legal Assistance	ARAG	
Identity Theft Protection	Aura/MetLife	
Pet Insurance	Fetch	

DOMESTIC PARTNER DISCLAIMER

Is My Domestic Partner Eligible?

Your domestic partner is eligible for coverage under the Company's plans if you meet one of these requirements:

- You have an active registered domestic partnership with a governmental body, or
- You both meet all of the following:
    - Are age 18 or older and legally competent
    - Have cohabitated for at least twelve months
    - Are not married to anyone else (even if legally separated)
    - Are not related by blood
    - Have financial interdependence, as demonstrated by joint ownership of real estate, bank accounts, mortgage, credit obligations, mutual beneficiary designations or powers of attorney

Dependent children of your domestic partner are also eligible for coverage if they are:

- Unmarried
- Primarily dependent on you or your partner for support
- Living with you (unless waived for student status)
- Meet age, student and incapacity requirements for the plan

Imputed Income and Tax Implications

If you add a family member to your coverage who is not considered a dependent under federal income tax law, your share of the cost of coverage must be paid on an after-tax basis. Your employer's share of the cost of benefits is also treated as taxable income, which is known as imputed income. The IRS considers health coverage for a domestic partner and/or their children a taxable benefit with imputed income that is subject to federal income tax and any other required payroll taxes.

Changes in Domestic Partnerships

When enrolling your domestic partner in coverage, you agree that you will notify the Company of any changes in your partnership status that would make your partner and/or their children ineligible for coverage. You must submit a Notice of Change in Domestic Partnership within 30 days of the change. Termination of coverage for domestic partners (and, in some cases, for children of domestic partners) is not a qualifying event for the purpose of continuing coverage under COBRA.

Required Documentation

Employees wishing to enroll a domestic partner for the first time will need to submit an Affidavit of Domestic Partnership to the Benefits Department prior to completing their enrollment. Please contact the Benefits Department at USHRBenefits@graham.ca for more information.

BENEFIT ENROLLMENT

Enrollment Periods

Annual Open Enrollment

Each calendar year, the Company conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 30 days of their date of hire or within 30 days of the date they become eligible.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Open Enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent and made within 31 days of the QLE.

Qualifying life events (QLEs) that may allow you to make benefit changes:

- Change in legal marital status
  - Marriage
  - Divorce, legal separation, annulment
  - Death of your spouse
- Change in your eligibility
  - Taking or returning from a leave of absence
  - Change in work schedule or status that causes a gain or loss of eligibility
  - Change in family member's eligibility
- Change in the number of eligible children
  - Birth, adoption or death of a child
  - Child gains or loses eligibility for coverage under the plan
- They gain a benefit option or lose coverage
  - New coverage choices made during their employer's annual enrollment
  - You or your family member's COBRA coverage from another employer expires
  - You or your family member becomes eligible for or loses Medicare or Medicaid
  - You or your family member loses coverage under a government's or educational institution's plan

Click here to watch a video about QLEs.

HEALTH

MEDICAL COVERAGE

HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Regence Group Administrators, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

For more information on the HSA, see pages 22 & 23 in this benefit guide.

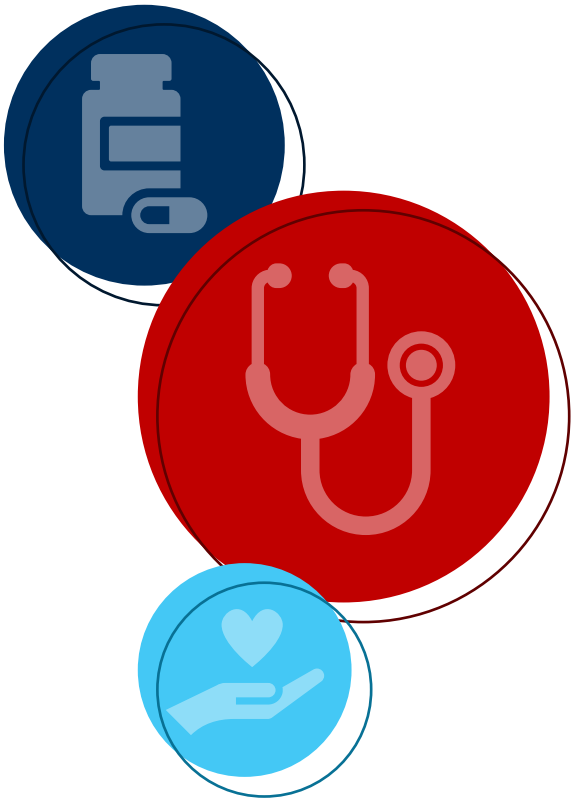
Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

To find an in-network provider, go to accessrga.com and select Washington. Then select the RGA Member Login button on the top of the page for access to the full search experience.

MEDICAL COVERAGE



PPO

The Preferred Provider Organization (PPO) plan, provided through Regence Group Administrators, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered "in-network." In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, go to accessrga.com and select Washington. Then select the RGA Member Login button on the top of the page for access to the full search experience.

Click here to watch a video about comparing medical plan types.

MEDICAL COVERAGE

HMO – CA Only

The Health Maintenance Organization (HMO) plan, provided through Kaiser Permanente, has a network of providers and hospitals that discount their services. With this plan, you select a primary care provider (PCP) from the participating network of providers, who will coordinate your health care needs, refer you to specialists (if needed) and approve further medical treatment. Services received outside of the HMO's network are not covered, except in the case of emergency medical care. For HMOs, premiums and out-of-pocket costs are typically low as long as you stay within the HMO plan's network.

How You Pay for Services

- You pay a predetermined flat dollar amount—or copay—for services received from your PCP.
- You must obtain a referral for treatment from outside specialists and certain types of tests and procedures. **Note:** Women generally do not need a referral to see an obstetrician/gynecologist or OB-GYN for routine care.
- If you go outside of the HMO's network, you are responsible for 100% of the cost of the services you receive.

To find an in-network provider, go to kp.org. Then select the Sign in button on the top of the page for access to the full search experience.

Click here to watch a video about comparing medical plan types.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	REGENCE GROUP ADMINISTRATORS (RGA)			
	HDHP 4K + HSA (Option 1)		HDHP 2K + HSA (Option 2)	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$4,000[2] / $8,000	$10,000[2] / $20,000	$2,000[2] / $4,000	$5,000[2] / $9,000
Out-of-Pocket Max (Individual/Family)	$10,000[3] / $20,000	$20,000[3] / $40,000	$4,000[3] / $8,000	$10,000[3] / $20,000
Office Visits (physician/specialist)	20%*	50%*	20%*	50%*
Routine Preventive Care	No Charge	50%*	No Charge	50%*
Virtual Visits (MD Live/Telehealth)	$10 copay / 20%*	Not Covered / 50%*	$10 copay / 20%*	Not Covered / 50%*
Diagnostics (lab/X-ray)	20%*	50%*	20%*	50%*
Complex Imaging	20%*	50%*	20%*	50%*
Chiropractic	20%*	50%*	20%*	50%*
Ambulance	20%*		20%*	
Emergency Room	20%*		20%*	
Urgent Care Facility	20%*	50%*	20%*	50%*
Inpatient Hospital Stay	20%*	50%*	20%*	50%*
Outpatient Surgery	20%*	50%*	20%*	50%*
Hearing Exam (1 per calendar year)	No Charge	50%*	No Charge	50%*
Hearing Hardware	20%* ($5,000 every 3 calendar years)		20%* ($5,000 every 3 calendar years)	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is aggregate. This means that the family deductible must be met before the plan will begin to pay coinsurance for any family member.
3. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	REGENCE GROUP ADMINISTRATORS (RGA)		KAISER PERMANENTE
	PPO		HMO - CA Only
	In-Network	Out-of-Network[1]	In-Network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000	$250 / $500
Out-of-Pocket Max (Individual/Family)	$5,000 / $10,000	$10,000 / $20,000	$1,500 / $3,000
Office Visits (physician/specialist)	$40 copay / $60 copay	50%*	$20 copay / $30 copay
Routine Preventive Care	No Charge	50%*	No Charge
Virtual Visits (MD Live/Telehealth)	$10 copay / $40 (PCP) or $60 (Specialist) copay	Not Covered / 50%*	No Charge
Diagnostics (lab/X-ray)	20%	50%*	$10 copay
Complex Imaging	20%	50%*	$75 copay
Chiropractic	$40 copay	50%*	$15 copay
Ambulance	20%*		$100 copay
Emergency Room	$250 copay + 20%*		$100 copay
Urgent Care Facility	$60 copay	50%*	$20 copay
Inpatient Hospital Stay	20%*	50%*	$300 copay*
Outpatient Surgery	20%*	50%*	$300 copay*
Hearing Exam (1 per calendar year)	No charge	50%*	Not Covered
Hearing Hardware	20%* ($5,000 every 3 calendar years)		Not Covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
3. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Click here to watch a video about preventive care.

VIRTUAL VISITS
RGA ENROLLEES

MDLive

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program will cost you a flat $10 copay/fee on the PPO plan and on the HDHP plan, regardless of your condition.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call 877-596-8826 or visit accessrga.com

Click here to watch a video about how telehealth works.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

VIRTUAL VISITS

KAISER ENROLLEES ONLY (CA ONLY)

Kaiser Virtual Care

Our virtual care program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our virtual visit program will cost you nothing, regardless of your condition.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A virtual visit medical professional is never more than a phone call, click or tap away! Call 866-454-8855 in Northern California, 833-574-2273 in Southern California or visit kp.org/getcare

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- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

PRESCRIPTION COVERAGE

Click here to watch a video about prescription drug coverage.

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit www.optumrx.com or call 800-334-8134.

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the OptumRx program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key Benefits	REGENCE GROUP ADMINISTRATORS (RGA)			
	HDHP 4K + HSA (Option 1)		HDHP 2K + HSA (Option 2)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Rx Deductible	Medical Deductible Applies	Medical Deductible Applies	Medical Deductible Applies	Medical Deductible Applies
Retail Pharmacy (30-day supply)				
Tier 1	20%*		20%*	
Tier 2				
Tier 3				
Tier 4				
Mail Order Pharmacy (90-day supply)				
Tier 1	20%*	Not Covered	20%*	Not Covered
Tier 2				
Tier 3				
Tier 4				

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

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When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit www.optumrx.com or call 800-334-8134.

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If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key Benefits	REGENCE GROUP ADMINISTRATORS (RGA)		KAISER PERMANENTE
	PPO		HMO - CA Only
	In-Network	Out-of-Network	In-Network
Rx Deductible	$150 / $450		None
Retail Pharmacy (30-day supply)			
Tier 1	$20		$10
Tier 2	$40*		$30
Tier 3	$60*		$30
Tier 4	$150*		$100
Mail Order Pharmacy (90-day supply / 100-day supply)			
Tier 1	$40	Not Covered	$20
Tier 2	$80*		$60
Tier 3	$120*		$60
Tier 4	N/A		N/A

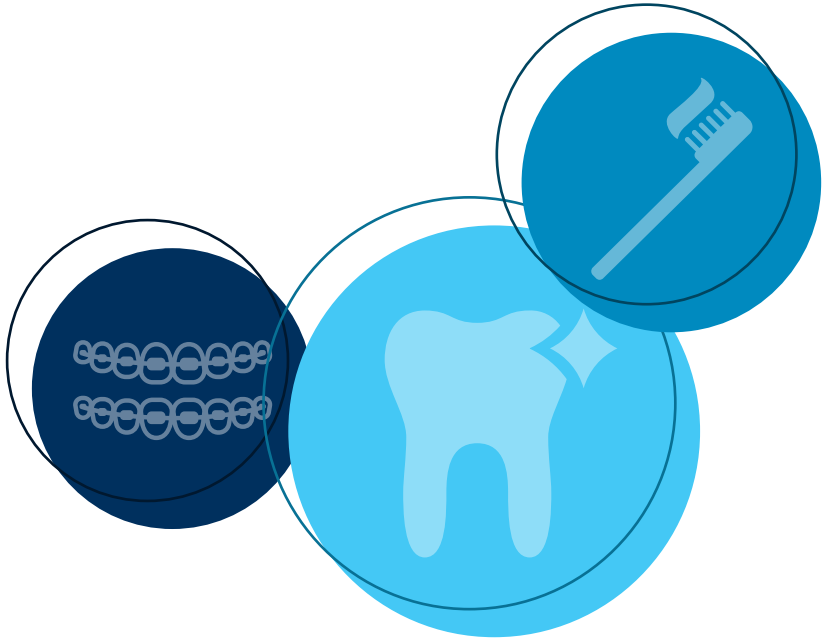
Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

DENTAL COVERAGE

HMO

With the dental Health Maintenance Organization (HMO) plan, DeltaCare provided through Delta Dental, you choose a primary dental provider to manage your care. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre-set charges apply to other services.

To find an in-network provider, go to deltadentalins.com/deltacare. Scroll down to Find a Dentist and enter your address or zip code. Select DeltaCare under Choose your network.



DENTAL COVERAGE

PPO

The dental Preferred Provider Organization (PPO) plan, provided through Delta Dental, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental PPO network.

To find an in-network provider, go to deltadentalwa.com. Select Online tools and Find a Dentist.

DENTAL COVERAGE

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	DeltaCare HMO	Delta Dental PPO	
	In-Network Only	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	None	$50 / $150	
Annual Benefit Maximum (per person)	None	$2,000	
Preventive Services	No Charge for most services	No Charge	
Basic Services	Copay based on type of service	20%*	
Major Services	Copay based on type of service	50%*	
Orthodontic Services	Copay based – covers Adults & Children	50% to $2,000 - Adults & Children	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. Preventive services do not apply toward the annual benefit maximum.

VISION COVERAGE

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through Ameritas, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the EyeMed or VSP network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

To find an in-network provider, go to EyeMedvisioncare.com or vsp.com

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Ameritas EyeMed				Ameritas VSP			
	EyeMed Network		Out-of-Network Reimbursement		VSP Choice Network		Out-of-Network Reimbursement	
Exam (once every 12 months)	$10 copay		Up to $35		$10 copay		$10 copay, covered up to $45	
Materials Copay	$20 copay		N/A		$20 copay		$20 copay	
Frames (once every 24 months)	Standard: Up to $200	Safety: N/A	Standard: Up to $90	Safety: N/A	Standard: Up to $200	Safety: Up to $65	Standard: Up to $90	Safety: Up to $25
Lenses (once every 12 months)								
Single Vision	Standard: No Charge after materials copay		Up to $25	N/A	Standard & Safety: No Charge after materials copay		Standard & Safety: Up to $30	N/A
Bifocal			Up to $40	N/A			Standard: Up to $50	Safety: Up to $45 / N/A
Trifocal			Up to $55	N/A			Standard: Up to $65	Safety: Up to $60 / N/A
Contact Lenses (in lieu of glasses; once every 12 months)								
Medically Necessary	No Charge		Up to $200		No Charge		Up to $210	
Elective	Up to $150		Up to $144		Up to $150		Up to $144	

WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP plan features an HSA provided through HSA Bank. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- The Graham Group contributes the following amounts annually to your HSA account to help it grow:
    - $1,000 individual / $2,000 family employer contribution per year (prorated per pay period).
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2027
Individual	$4,500
Family	$9,000
Catch-up Contributions	$1,000

Click here to watch a video about HSA limits.

HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,[1] retire or leave the organization.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

Click here to watch a video about how an HSA works.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through HSA Bank, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA (HCFSA)	Limited-Purpose FSA (LPFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be enrolled in either the RGA PPO $1,500 or Kaiser Permanente HMO $250 (CA Only); enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	You must be enrolled in the HDHP 4k or HDHP 2k plan	Available to all eligible employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Dental and vision coinsurance only • Dental and vision deductibles only • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	$3,400	$3,400	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds of up to $680 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $680 will **not** be returned to you or carried over to the following year.
- **LPFSA:** This type of account can be used toward eligible dental and vision expenses only.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.

Click here to watch a video about how an FSA works.

Click here to watch a video comparing an HSA and an FSA.

COMMUTER BENEFITS

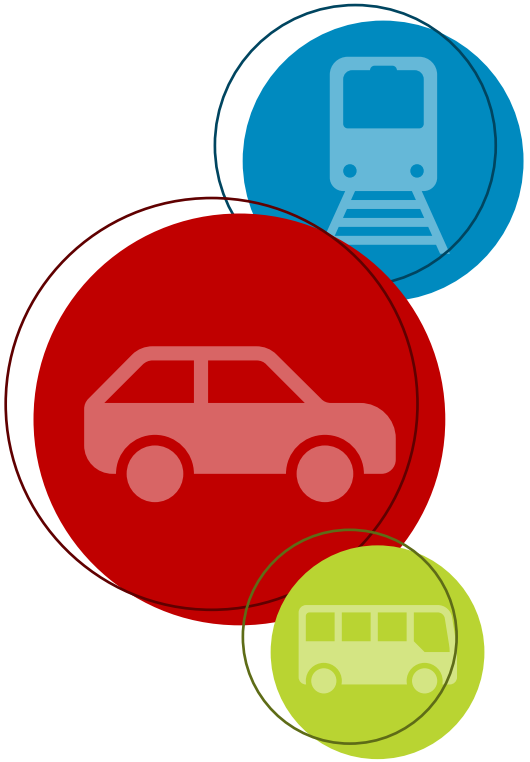
This program, provided through HSA Bank, allows you to save pre-tax dollars to offset the cost of transit and parking, reducing your overall commuting expenses. You set aside pre-tax funds in a commuter benefits account through automatic payroll deductions, thus decreasing your taxable income and reducing your income taxes, so you end up with more money in your paycheck.

IRS-approved, eligible expenses fall into two types of accounts:

	Transit	Parking
Monthly Limit	$325	$325
Examples of Eligible Expenses	• Bus • Commuter train • Ferry • Subway • Vanpooling	• Parking at or near your workplace • Transit station parking

Click here to watch a video about how commuter benefits work.

*The limits reflected here are for 2027.



401(K) RETIREMENT SAVINGS ACCOUNT

According to experts, you should aim to have 70–80% of your pre-retirement income saved by the time you retire. With help from the 401(k) provided through Empower, you can help secure your financial future. Whether retirement is decades away or just around the corner, the time to save for retirement is today.

The Basics

- The 401(k) is a tax-advantaged savings account that lets you save money for retirement.
- You can contribute either pre-tax or after-tax tax funds through automatic payroll deductions.
- You can then invest your funds through a mix of stocks, bonds and cash to help your account grow faster.
- How much you can contribute depends on the annual limits set by the IRS. Catch-up contributions are also allowed if you are age 50 or older. See the chart below for details.

Employer Match and Vesting

To help the account grow, we match your contributions as outlined in the following chart:

	2027 Contribution Amount
Employer Match	100% match on 1st 4%
Catch-up Contribution	Age 50-59 or 64 and over $7,500* Age 60-63 $11,250*
Annual Contribution Limit	$23,500*
Maximum Possible Contribution	Age 50-59 or 64+ $31,000* Age 60-63 $34,750*

Your contributions are fully vested, meaning you own them outright.

Roth 401(k) Option

In addition to the traditional 401(k), the Company also offers a Roth 401(k) option. Unlike a traditional 401(k), you contribute after-tax funds, which means the money you put into the account has already been taxed. Once you retire, any withdrawals you make from your account are tax free, provided:

- The withdrawal is a qualified distribution.
- You've held the account for at least five years.
- The withdrawal is made due to a disability, on or after your death or once you turn age 59 ½.

Click here to watch a video about how a retirement plan works.

*The limits reflected here are for 2027.

LIFE INSURANCE

Life insurance, provided through New York Life Insurance Company, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	2x your annual salary to a maximum of $500,000

Voluntary Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	$10,000 increments up to the lesser of $500,000 or 5 x salary	$200,000
Spouse	$5,000 increments up to the lesser of $250,000 or 50% of Employee benefit	$25,000
Child(ren)	Birth to 6 months: $500 6 months+: $10,000	$10,000

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

IMPUTED INCOME

Imputed income is the value of non-monetary compensation or benefits provided to you by the company, such as health insurance premiums and life insurance coverage. Even though these benefits are not received in cash form, they are considered part of your overall compensation package and are subject to taxation.

Under federal tax law, if the total coverage of your company-paid basic life insurance is more than $50,000, the premium paid for the coverage above $50,000 is considered imputed income and will be added to your W-2 earnings. You must pay federal, state and Social Security taxes on this amount.

Click here to watch a video about how life insurance works.

DISABILITY INSURANCE

Disability insurance, provided through New York Life Insurance Company, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Voluntary Short-Term Disability

Provided at an affordable group rate.	
Benefit	70% of base salary
Maximum weekly benefit	$3,000
When benefit begins	After 14th day of disability
When benefit ends	11 weeks

Long-Term Disability

Provided at NO COST to you.	
Benefit	60% of base salary
Maximum monthly benefit	$15,000
When benefit begins	After 90th day of disability
When benefit ends	SSNRA

Click here to watch a video about how disability insurance works.

STATE-MANDATED DISABILITY & PAID FAMILY LEAVE PROGRAMS

Employees who reside in one of the states or districts below may be eligible for statutory disability and/or family leave coverage provided by their state. State-provided benefits will be administered and paid out by the state in accordance with state laws and they may run concurrently with family medical leave (FMLA) and short-term disability (STD). Employees are responsible for applying to these programs with the applicable state agencies. **Note:** The number of states that offer statutory disability and paid family leave coverage may change at any time.

- California State Disability Insurance (SDI)
- California Paid Family Leave (PFL)
- Colorado Paid Family & Medical Leave Insurance (FAMLI)
- Connecticut Paid Family Medical Leave (PFML)
- Massachusetts Paid Family & Medical Leave (PFML)
- New Jersey Temporary Disability Benefits (TDB)
- New Jersey Family Leave Insurance (FLI)
- New York Disability Benefits Law (DBL)
- New York Paid Family Leave (PFL)
- Oregon Paid Family Medical Leave Insurance (PFMLI)
- Rhode Island Temporary Disability Insurance (TDI)
- Washington Paid Family and Medical Leave (PFML)
- Washington D.C. Paid Family and Medical Leave (PFML)

VOLUNTARY BENEFITS

Accident Insurance

Accident insurance, provided through New York Life Insurance Company, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

Accident Insurance in Practice	
Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	Plan 1 - $2,075 Plan 2 - $2,800

Click here to watch a video about how an accident plan works.

VOLUNTARY BENEFITS

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt.[1] With critical illness insurance provided through New York Life Insurance Company, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

Critical Illness Insurance in Practice	
Situation	Britta had a heart attack while raking leaves.
Covered Benefits	Heart attack diagnosis
Total Benefit Paid Directly to Employee	100%

Click here to watch a video about how a critical illness plan works.

1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

VOLUNTARY BENEFITS

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a stint at the hospital, which can cost an average of $3,025 per inpatient day.[1] Hospital indemnity, provided through New York Life Insurance Company, pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

Hospital Indemnity Insurance in Practice	
Situation	Craig was hospitalized following a car accident.
Covered Benefits	• Hospital admission • Hospital stay • Intensive care unit stay
Total Benefit Paid Directly to Employee	$1,600

Click here to watch a video about how a hospital indemnity plan works.

1. Kaiser Family Foundation. "Expenses per Inpatient Day." Kaiser Family Foundation, kff.org/health-costs/state-indicator/expenses-per-inpatient-day.

VOLUNTARY BENEFITS

Pet Insurance

Your pet is a member of your family, and they deserve to be covered as one. You have access to discounted rates on pet insurance to help cover the costs of veterinary services. From routine visits to emergencies, gain peace of mind knowing your best friend can receive the care they need without breaking the bank.

Pet insurance, provided through Fetch, reimburses all or part of the cost of covered veterinary expenses, either as a percentage of your cost or based on a schedule of set dollar amounts. You can visit any vet of your choice and customize coverage to meet your needs.

What's Covered?

Coverage varies based on the plan you select. Below are examples of services that may be covered (check plan details to verify).

Accidents, Illness and More:

- Vet exams and diagnostic testing
- Hospitalization and surgery
- Emergency and specialist care
- Prescription pet medications
- Treatment for serious issues and hereditary conditions
- Continuing care for chronic conditions
- Disaster response

Preventive Care:

- Routine exams and immunizations
- Preventive medication
- Spay/neuter surgery
- Teeth cleaning

Exclusions:

- Pre-existing conditions
- Cosmetic procedures
- Injuries caused by cruelty or neglect

Click here to watch a video about how pet insurance works.

QUESTIONS?

To learn more, visit fetchpet.com

For questions, contact Fetch at (866) 509-0163.

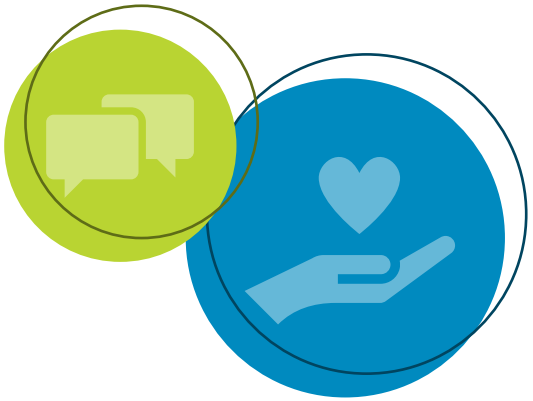
WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through ComPsych.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships or marital conflicts
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues



EAP Benefits

- Assistance for you and your household members
- 5 face to face, video and self-directed counseling
- Unlimited toll-free phone access and online resources
- 24/7 Service Center Access
- Perks and Savings

QUESTIONS?

To learn more, visit www.compsych.com

For questions, contact ComPsych at 800-851-1714.

Click here to watch a video about how an EAP works.

MENTAL HEALTH BENEFITS

RGA ENROLLEES ONLY

talkspace	nocd	AbleTo
General Mental Health • Includes: Stress, Anxiety, depression, eating disorders, sleep, identity struggles, trauma, grief, relationships, chronic issues, substance use, healthy living	Obsessive Compulsive Disorder (OCD)	General Mental Health • Includes: Stress, Anxiety, depression, eating disorders, sleep, identity struggles, trauma, grief, relationships, chronic issues, substance use, healthy living
Talkspace offers a range of virtual mental health treatment options to choose from, including online therapy, coaching, self-help tools, psychotherapy, and medication management. For members ages 13 and older.	NOCD provides therapy for OCD through live sessions with a licensed, specialized therapist. For members ages 6 and older.	AbleTo Therapy+ provides mental health care through an eight-week online therapy program. Sessions are one-to- one with a licensed therapist, and digital tools give you extra support. For members ages 18 and older.
Visit: talkspace.com/partnerinsurance State(s) Available: All 50 States	Visit: nocd.com Call: (312) 766-6780 State(s) Available: WA, OR, ID, UT	Visit: ableto.com Call: (866) 287-1802 State(s) Available: WA, OR, ID, UT

Click here to watch a video about mental health.

MENTAL HEALTH BENEFITS

KAISER ENROLLEES ONLY (CA ONLY)

Members can get help with depression, anxiety, stress, addiction, and mental or emotional health – without a referral for mental health care within Kaiser Permanente. Share your concerns with anyone on your care team at any time, and they can connect you to the support you need, including:

INDIVIDUAL OR GROUP THERAPY

With multiple options to fit your journey.

MEDICATION

To manage a diagnosed condition.

SELF-CARE RESOURCES

Including wellness coaching and more.

MENTAL WELLNESS APPS[1]

For stress, sleep, and healthy habits.

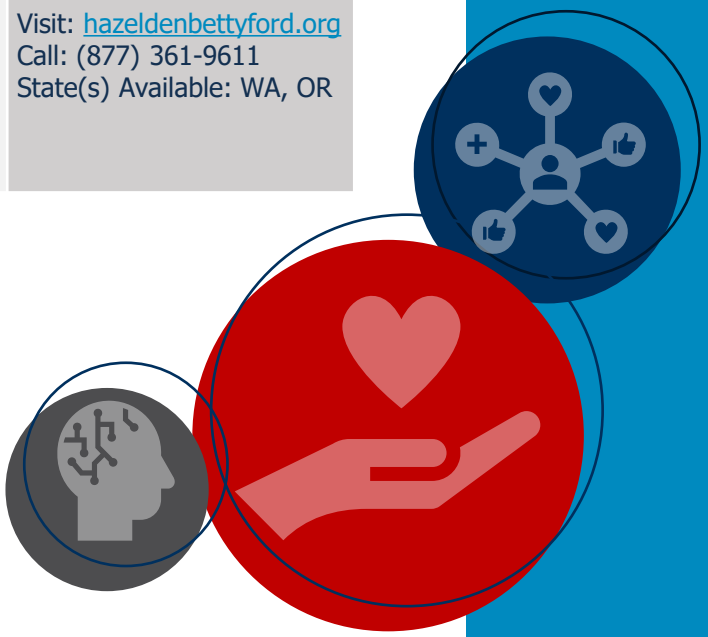
Visit **kp.org/choosekp** and go to "Take advantage of tools that support your health."

Click here to watch a video about mental health.

ADDICTION HELP

RGA ENROLLEES ONLY

Boulder	eleanor health	charlie health	Hazelden Betty Ford Foundation
Substance Use Disorders: • Opioid Use Disorder (OUD) • Alcohol Use Disorder (AUD)	Substance Use Disorder •General Mental Health	• Trauma • Substance Use Disorder • LBTQ Support • Intensive Outpatient • Dialectical Behavioral Therapy	Substance Use Disorder •Mental Health Treatment
Boulder care offers virtual treatment for substance use disorders, including medication-assisted treatment, peer coaching, care coordination and other recovery tools. For members ages 18 and older.	Eleanor Health provides virtual and in-person support including medication-assisted treatment, psychiatry, therapy and counseling, and recovery coaching. For members ages 18 and older.	Charlie Health offers virtual and in-person intensive outpatient treatment. For members ages 12-30.	Hazelden Betty Ford offers in- person and virtual therapy, high-intensity outpatient programs and medication- assisted treatment. For members ages 18 and older.
Visit: boulder.care Call: (866) 347-9635 State(s) Available: WA, OR, ID, UT	Visit: eleanorhealth.com Call: (866) 323-2596 State(s) Available: WA	Visit: charliehealth.com Call: (866) 540-1828 State(s) Available: WA, OR, ID, UT	Visit: hazeldenbettyford.org Call: (877) 361-9611 State(s) Available: WA, OR



PREVENTION AND MANAGEMENT

RGA ENROLLEES ONLY

Omada Health

Keep muscle and joint pain at bay! Thanks to Omada Health, you don't have to turn to expensive surgical or medication options to ease your muscle and joint pain. Omada Health's digital exercise therapy is an easy, effective and customized solution that will get you back on your feet.

When you sign up for the therapy program, you'll get:

- To meet with a licensed physical therapist for an initial assessment and to create a care plan.
- A personalized therapy program with exercises and stretches your PT will assign for you to do at your own pace.
- Throughout treatment you can schedule video visits with your physical therapist for questions and help setting goals.

To learn more or join, log in to the RGA member portal at accessrga.com, choose Washington and select the RGA Member Login Button. After logging in to your RGA account select "Explore Your Benefits" then select "Go to virtual physical therapy" .

PHYSICAL HEALTH BENEFITS

KAISER ENROLLEES ONLY (CA ONLY)

Craving a yoga class or cooking workshop? How about massage therapy or wellness coaching? Whatever your style, you've got convenient perks for your entire health journey.

RESOURCES FOR A HEALTHY LIFESTYLE

To boost your diet, stress less, quit smoking, or manage a condition.

GYMS, STUDIOS, AND MORE

Power up with a fitness membership from One Pass Affinity.[1]

WELLNESS COACHING

Work one-on-one with a personal coach to set and reach specific health goals – at no cost.

CLASSES AND GROUPS

Find the perfect class for you, online or in person. Some classes may require a fee.

EARN HEALTHY REWARDS

Earn up to $150 in rewards for completing simple, healthy activities.[2]

Visit kp.org/choosekp and go to "Take advantage of tools that support your health."

VOLUNTARY BENEFITS

Legal Assistance Through ARAG

Dealing with legal issues can be daunting, but thanks to the legal assistance plan provided through ARAG, you don't have to waste time looking for the right attorney or spend a fortune on legal fees.

The legal plan provides you, your spouse and eligible dependents with fully covered legal services from experienced attorneys. Receive legal services for a wide range of personal matters such as:

- Criminal matters
- Debt
- Divorce
- Estate planning
- Family
- Real estate
- Small claims court
- Taxes

Features

- **In-Office Services** — You will receive access to a nationwide network of credentialed attorneys who can advise and represent you.
- **Telephone Advice** — You can call a network attorney for unlimited legal advice to help prepare documents, letters or a will.
- **Online Resources** —Turn to online tools and useful information to learn more about legal issues and create legally valid documents on your own.

Click here to watch a video about how legal assistance works.

QUESTIONS?

To learn more, visit www.araglegal.com.

For questions, contact ARAG at (800) 247-4184.

VOLUNTARY BENEFITS

Identity Theft Protection Through Aura via MetLife

Your identity is made up of more than your Social Security number and credit score. It includes the trail of data you leave behind from financial transactions, as well as what you share on social media. That's why we offer identity theft protection, provided through Aura via MetLife for you and your family members.

Features

- $1 million ID theft insurance
- Dark web monitoring
- High-risk transaction monitoring
- Social media monitoring
- IP address monitoring
- Lost wallet protection
- Solicitation reduction
- Credit monitoring and alerts
- Data breach notifications
- Stolen 401(k) and HSA funds reimbursement

QUESTIONS?

To learn more, visit www.metlife.com.

For questions, contact Aura at (844) 931-2872.

Click here to watch a video about how identity theft protection works.

PERKS

EMPLOYEE DISCOUNTS

BenefitHub

BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more! To get started:

- Go to mypathperks.benefithub.com
- Use Referral Code: **K7WEWL**
- Complete Registration

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

Other Discount Sites:

RGA: accessrga.com Choose Washington and select the RGA Member Login button. After logging in to your RGA account, select "Explore Your Benefits" then select "Health & Wellness Discounts"

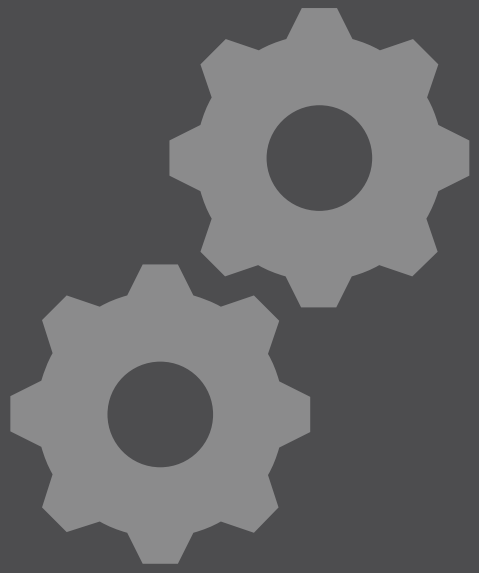
MEDICARE GUIDANCE

HUB Medicare Advocacy

The HUB Senior and Individual Team Medicare advocacy service is available at no cost to you and your family members who are approaching Medicare eligibility and/or who are already Medicare eligible. HUB can:

- Answer basic questions about Medicare coverage and enrollment
- Provide guidance on how to avoid late enrollment penalties and coverage gap pitfalls, including COBRA
- Compare current coverage to Medicare and explain the differences between the two
- Provide retiree benefits counseling
- Help individuals shopping for Medicare Supplement Plans, Advantage Plans and Part D

For more information or to get started, call 833-482-7471 or email Senior.IFP@hubinternational.com.



RESOURCES

GRAHAM GROUP BENEFITS WEBSITE

Benefits Information on the Go

The Benefits website is your centralized hub for important benefit information and resources.

Visit the Benefits website for:

- Plan information
- Premium rates
- Coverage details
- Annual notices
- Enrollment instructions
- And other helpful resources to support your benefit decisions.

Access the benefit website at www.grahambuilds.com/us-benefits/ or by scanning the QR code below.

Please note that the website is password protected. When prompted, enter the password: **GGUSBenefits**

BENEFIT SPOT

Benefits Information on the Go

With Benefit Spot, you can access your benefits anytime, anywhere, even when away from work.

Use Benefit Spot to:

- Access your Benefits Guide
- Watch educational videos
- Find benefit contact information
- Estimate costs for common health care procedures
- And more.

Download the app by searching "Benefit Spot" in the Apple App Store or Google Play or scan the QR code below.

When you launch the app, enter company code GrahamGroup to access your plan information. (**Note:** The company code is case-sensitive.)

IMPORTANT CONTACTS

Benefit	Carrier	Phone Number	Website/Email
Medical	PPO: Regence Group Administrators	866-738-3924	accessrga.com
	HMO: Kaiser Permanente (CA Only)	888-901-4636	kp.org
24-Hour Nurse Advice Line	Regence Group Administrators	800-807-1370	
Virtual Visits	MDLive	877-56-8826	accessrga.com
	Kaiser Virtual Visits (CA Only)		
Prescription (RGA Enrollees)	RxBeneifts (OptumRx Formulary)	800-334-8134	member.rxbenefits.com
Dental	DHMO: DeltaCare through Delta Dental	800-422-4234	deltadentalins.com/deltacare
	DPPO: Delta Dental	800-554-1907	deltadentalwa.com
Vision	Ameritas	800-659-2223	ameritas.com
Health Savings Account (HSA)	HSA Bank	800-357-6246	hsabank.com
Flexible Spending Account (FSA)	HSA Bank	800-357-6246	hsabank.com
Commuter Benefit	HSA Bank	800-357-6246	hsabank.com
Life and AD&D & Disability	New York Life Insurance Company	800-225-5695	www.mynyl.newyorklife.com
Voluntary Benefits	New York Life Insurance Company	800-225-5695	www.mynyl.newyorklife.com
Employee Assistance Program (EAP)	ComPsych	800-851-1714	www.compsych.com
Legal Assistance	Aura via MetLife	844-931-2872	www.metlife.com/identity-and-fraud-protection
Identity Theft Protection	ARAG	800-247-4184	www.araglegal.com
Pet Insurance	Fetch Pet Insurance	866-509-0163	fetchpet.com
401(k) Retirement Savings	Empower	888-411-4015	participant.empower-retirement.com/participant/#login

ANNUAL NOTICES

Annual notices can be found on the Benefits Website

BENEFIT SUMMARIES

Benefit Summaries can be found the Benefits Website

PLAN CONTRIBUTIONS
MONTHLY

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	Employee Monthly Contributions			
	HDHP 4K	HDHP 2K	PPO	HMO
Employee Only	$0.00	$38.84	$92.06	$93.07
Employee + Spouse	$0.00	$82.76	$196.19	$614.24
Employee + Child(ren)	$0.00	$71.80	$170.22	$558.40
Employee + Family	$0.00	$116.12	$275.27	$837.60

Dental

Coverage	Employee Monthly Contributions	
	DHMO	DPPO
Employee Only	$0.00	$25.45
Employee + Spouse	$0.00	$51.10
Employee + Child(ren)	$0.00	$59.97
Employee + Family	$0.00	$87.52

Vision

Coverage	Employee Monthly Contributions	
	EyeMed	VSP
Employee Only	$0.00	$0.00
Employee + Spouse	$6.32	$7.44
Employee + Child(ren)	$5.58	$6.70
Employee + Family	$8.68	$9.80

PLAN CONTRIBUTIONS

BI-WEEKLY

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	Employee Bi-Weekly Contributions			
	HDHP 4K	HDHP 2K	PPO	HMO
Employee Only	$0.00	$17.92	$42.49	$42.95
Employee + Spouse	$0.00	$38.20	$90.55	$283.50
Employee + Child(ren)	$0.00	$33.14	$78.56	$257.72
Employee + Family	$0.00	$53.59	$127.05	$386.59

Dental

Coverage	Employee Bi-Weekly Contributions	
	DHMO	DPPO
Employee Only	$0.00	$11.75
Employee + Spouse	$0.00	$23.58
Employee + Child(ren)	$0.00	$27.68
Employee + Family	$0.00	$40.39

Vision

Coverage	Employee Bi-Weekly Contributions	
	EyeMed	VSP
Employee Only	$0.00	$0.00
Employee + Spouse	$2.92	$3.43
Employee + Child(ren)	$2.58	$3.09
Employee + Family	$4.01	$4.52

PLAN CONTRIBUTIONS
WEEKLY

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	Employee Weekly Contributions			
	HDHP 4K	HDHP 2K	PPO	HMO
Employee Only	$0.00	$8.96	$21.25	$21.48
Employee + Spouse	$0.00	$19.10	$45.27	$141.75
Employee + Child(ren)	$0.00	$16.57	$39.28	$128.86
Employee + Family	$0.00	$26.80	$63.52	$193.29

Dental

Coverage	Employee Weekly Contributions	
	DHMO	DPPO
Employee Only	$0.00	$5.87
Employee + Spouse	$0.00	$11.79
Employee + Child(ren)	$0.00	$13.84
Employee + Family	$0.00	$20.20

Vision

Coverage	Employee Weekly Contributions	
	EyeMed	VSP
Employee Only	$0.00	$0.00
Employee + Spouse	$1.46	$1.72
Employee + Child(ren)	$1.29	$1.55
Employee + Family	$2.00	$2.26

BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, the PPO plan features an in-network family deductible of $3,000. If one member of the family satisfies the individual $1,500 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $1,500, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, the PPO plan features a family out-of-pocket maximum of $10,000. If one member of the family satisfies the individual out-of-pocket maximum of $5,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts.

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic.

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs.

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

BENEFIT TERMINOLOGY

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Click here to watch a video about benefits terms.