SNOHOMISH COUNTY
PUD
PUBLIC UTILITY DISTRICT NO. 1



2027 BENEFITS GUIDE

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This Benefits Guide is primarily information on the District's Employee Health Benefits Program (the "Plan") that allows employees to choose the benefits and coverage levels that work best for them and their family. Benefit choices under the Plan include medical, dental, vision, life insurance, long-term disability, flexible spending accounts, health savings account and voluntary benefit coverages (critical illness, accident, and hospital indemnity insurance).

There are other benefits that an employee receives outside of the Plan, such as paid-time off, Retirement Health Savings (RHS), Employee Assistance Program (EAP), and Tuition Reimbursement..

This booklet also touches on employee retirement benefits and savings options. Use the resources cited on those pages to learn more.

Find more information at teampud.com/benefits

Or to navigate from the teampud.com home page, go to HELPFUL RESOURCES in the top navigation, then under HEALTH & WELLNESS click on Health Benefits.



MEDICARE PART D DISCLOSURE NOTICE: PAGE 22

Legal Notice:

This guide is a summary that has been prepared to give employees a brief overview of the benefits available. It is in no way a binding contract and should be viewed as an explanation only. If there is a conflict between the information in this document and the plan(s) source documents, the latter will govern. The District established the plan(s) outlined in this document with the intention that it will be maintained indefinitely. However, the District reserves the right at any time to amend any or all provisions of the plan(s) described herein or terminate the plan(s), in whole or in part, for any reason.

This section:
Employee Eligibility • Dependent Eligibility • Coverage Levels • District Contribution • Enrollment and Change Opportunities

General Information

Employee Eligibility

All regular full-time employees and regular part-time employees, including the District's Commissioners, are eligible to participate in the District's Plan.

Employees enroll in the Plan when they first become eligible and can make election changes during the annual Open Enrollment period. See the Employee Health Benefits Program document on teampud.com/benefits for more details.

When Does Coverage Become Effective?

Newly eligible employees will receive the monthly benefits and District Contribution for the Employee Health Benefits Program as follows:

- Hired between the 1st through the 15th of a month, Benefits and Distrct Contribution will be effective on the 1st of the next calendar month. (Example: hired June 1-15, Benefits and District Contribution effective July 1.)
- Hired between the 16th through the end of the month, Benefits and the District Contribution will be effective the first of the third calendar month of employment. (Example: hired June 16-30, Benefits and District Contribution effective August 1.)

Dependent Eligibility

Refer to each specific benefit plan document to verify dependent eligibility under the plan

Eligibility for dependents under each District plan varies. Please review the following definitions for a summary of dependent eligibility under the various District plans.

For the District's medical, dental, vision, voluntary AD&D and voluntary term life (VTL) plans, dependent means:

- Your spouse, your state-registered domestic partner (SRDP) or your legacy domestic partner,
  - "Spouse" means your legal spouse.
  - "Legacy Domestic Partner" means a domestic partner who was on a District medical, dental or vision plan as of December 31, 2014, and has remained on a District plan continuously since that time.
  - "State Registered Domestic Partner" (SRDP) means a domestic partnership within the meaning of the Revised Code of Washington (currently one partner must be at least age 62 and registered as a domestic partnership in Washington state).
- Your child, adult child or disabled child. Grandchildren are not eligible.
  - "Child" means your natural child, adopted child, foster child or step-child, or the child of your legacy domestic partner or SRDP up to age 19.
  - "Adult Child" means your natural child, adopted child, foster child or step-child, or the child of your legacy domestic partner or SRDP age 19 up to age 26.
  - "Disabled Child" means your child who has attained age 26, is disabled, and meets the specific plan guidelines.

Domestic Partner Tax Implications:

If an employee covers a SRDP, legacy domestic partner or their child(ren) who is/are not the employee's tax dependent(s) as defined by the IRS, the value of health benefits for the SRDP, legacy domestic partner and/or their child(ren) constitute taxable income for the employee.

Cross Coverage

Each active District employee is eligible to cross cover their spouse, SRDP, legacy domestic partner and dependents on medical, dental and vision.

Cross coverage is not available for Voluntary Term Life (VTL) and Voluntary Accidental Death & Dismemberment (AD&D). District employees and dependents cannot be covered twice under the VTL and Voluntary AD&D policy.

Examples include:

- Employee and spouse both work at the District and decide to cover each other on their medical, dental and vision. Both would be considered cross covered.
- If the employee wanted to cover their spouse on VTL or Voluntary AD&D, the spouse would not be able to elect VTL or Voluntary AD&D for their own benefit elections.

Coverage Levels

The District's medical, dental and vision plans have four coverage levels. The cost of the benefit and District contribution (if applicable) varies by the coverage level selected for these benefits. The coverage levels are as follows:

- Employee only
- Employee + spouse/SRDP
- Employee + child(ren)
- Employee + family

District Contribution

Regular Full–time Employees

For full-time employees, the District contribution is based on an employee's coverage selection for the Plan's core benefit plan offerings. To be eligible to receive the District contribution toward benefits, full-time employees must receive at least 1 paid hour each month.

IMPORTANT
Regular full-time employees must be enrolled in medical, dental, long-term disability, core AD&D and core term life coverage (core benefits).

The Core Plans (employer paid) are:

- Medical
- Dental
- Core Term Life
- Long-Term Disability
- Core Accidental Death & Dismemberment

See Monthly Insurance Costs & Contribution on pages 30-32 for contribution amounts

Regular Part-Time Employees

Newly hired or newly eligible (i.e., change in employment status full-time to part-time) part-time employee benefit offers will be based on the anticipated hours worked per week (less or more than 30 hours per week), and will be reviewed one year from date of hire or date of employment status change.

Part-time employees will be reviewed each fall based on the prior year actual hours worked (i.e., in October 2026, look back at hours worked Oct. 16, 2025, to Oct. 15, 2026) to determine the benefits to offer for the next calendar year.

Part- time employees will be offered the following:

Benefits Offered Based on Time Worked

Hours per week	Benefits offered
Less than 30 hours	Medical, Dental, Vision, Health Care FSA, Dependent Care FSA, Health Savings Account (if enrolled in HDHP) *If enrolled employee would pay the full premium amount and will receive the Pay-in-lieu rate+*
At least 30 hours, but less than 40 hours	Optional (bundled) - Medical* (PPO, HMO, HDHP/HSA), Dental*, Vision Optional (stand-alone) - Health Care FSA, Dependent Care FSA **If enrolled, will receive District Contribution (see page 31 for amounts). If medical is waived, employee will receive the Pay-in-lieu rate+.*

+The Pay-in-lieu-rate is paid on straight-time hours only and the rate will be $7.12 per hour as of Jan. 1, 2027.

Part-time employees are not eligible for Long-Term Disability, Core Term Life, Core or Voluntary AD&D, or VTL coverages.

Enrollment & Change Opportunities

New Employees/Newly Eligible Employees

A new employee or newly eligible employee must enroll in benefits through Benefit Central within the deadline provided by Human Resources. Failure to complete enrollment by the deadline provided will result in the following default enrollment:

- Regular, full-time employees – HMO employee-only coverage, DEPO employee-only coverage, Core Term Life, Core AD&D and LTD.
- Regular, part-time employees – no benefits coverage.

Annual Open Enrollment

Employees eligible to participate in the Plan are provided an annual Open Enrollment each fall. During that time, employees may make changes to their benefit coverage, add or remove dependents, and enroll or re-enroll in a Flexible Spending Account (FSA). Information on benefit options, enrollment opportunities, requirements and deadlines is provided to employees. Other than Open Enrollment, the only time an employee may make a change to their benefits is when they have a qualified Life Event. For details (including deadlines), see the Mid-Year Life Events section below.

Mid-Year Life Events

Other than Open Enrollment, the only time benefits can be changed is when an employee has a qualified Life Event or special enrollment event as defined by the IRS and the District (i.e., marriage, divorce, birth, loss of other coverage, etc.)

Changes in benefit elections may be allowed consistent with the reason for the change and your ***Life Event must be initiated in Benefit Central within 30 days of the event.*** Coverage changes are generally effective the first of the month following the date following the date you enter the Life Event into Benefit Central.

Newborn or newly adopted children may be added to an employee's coverage effective upon the date of birth or assumption of a legal obligation for total or partial support of a child in anticipation of adoption. ***Employees must initiate a Life Event in Benefit Central within 60 days of a birth or adoption.***

NOTE

Removal of a legacy domestic partner from coverage due to a qualified Life Event will result in the domestic partner losing District coverage permanently. The child's coverage is effective retroactive back to date of birth/adoption.

A Life Event must be entered in Benefit Central within 30 days of the event (60 days for newborn or adopted children) to make a mid-year benefit change. Failure to initiate the event within this time-frame will impact your benefits, including losing the ability to add your dependent until the next Open Enrollment.

Documents supporting the life event must be submitted to Human Resources within 60 days from the effective date of the qualifying event.

COBRA Continuation Coverage

When dependents are no longer eligible for medical/dental/vision benefits, a qualified beneficiary may be eligible for benefit continuation rights under COBRA (Consolidated Omnibus Budget Reconciliation Act). To obtain COBRA coverage, a qualified beneficiary must make a COBRA election within 60 days of loss of eligibility. COBRA election information will be sent directly from Voya, the administrator for COBRA. For more info, contact HR Benefits at 425-783-8557 or hrbenefits@snopud.com.

Enrollment, Life Event and Effective Date Examples*

Event	Election Period	Benefit Effective Date	Changes Allowed
New Hire	Employee must elect benefits by the end of the month prior to their benefit effective date	Hired between the 1st through the 15th of a month, benefits and Distrct contribution will be effective on the 1st of the next calendar month. Hired between the 16th through the end of the month, benefits and the District Contribution will be effective the first of the third calendar month of employment.	• Ability to enroll in all eligible benefits • If elections not made within Election Period, full-time employee will be defaulted to: › Kaiser HMO – Employee-only coverage › Willamette DEPO – Employee-only coverage › Core Term Life › Core AD&D › LTD • Part-time employees are defaulted to no coverage
Employment Status Change	Within 30 days of event	• Event 1st day of month, effective that day • Event 2nd day of month through end of month, effective first day of following month	• Ability to enroll in all eligible benefits • If elections not made within Election Period, full-time employee will be defaulted to: › Kaiser HMO – Employee-only coverage › Willamette DEPO – Employee-only coverage › Core Term Life › Core AD&D › LTD • Part-time employees are defaulted to no coverage
Open Enrollment	Open Enrollment period (usually end of October)	January 1 of the following year	Can make any benefit changes; add/remove dependents. FSAs and HSAs must be re-elected each year.
Life Event (i.e., marriage, loss of other coverage, eligible for other coverage, etc.)	30 days from date of event	1st of month following date entered into Benefit Central	Changes must be consistent with life event
Life Event (divorce, loss of eligibility)	30 days from date of event	End of month from loss of eligibility. Ex-Spouse is no longer eligible end of the month in which divorce was final, regardless of when the Life Event is entered in Benefit Central.	Changes must be consistent with life event
Life Event – birth/adoption	60 days from date of event	Medical – benefits effective date of birth All other benefits – effective 1st of month following date entered in Benefit Central	Benefit changes consistent with life event

***NOTE:** *This is for illustrative purposes. For more information about Life Events and allowed benefit changes, please refer to the Employee Health Benefits Program document on* teampud.com/benefits.

Documentation of the life event must be provided to Human Resources within 60 days from the effective date of the qualifying event.

This section:
Medical • Prescription Drug Benefits • Dental • Coordination of Benefits • LTD • Core Term Life • Core AD&D

Core Pre-Tax Benefits Choices



Medical

Employees have the flexibility to choose among several medical plan options – a preferred provider organization (PPO) plan, a health maintenance organization (HMO) plan, and the High Deductible Health Plan (HDHP).

- The District's PPO and HMO plans require employees to pay deductibles/coinsurance and/or copays for most services. Primary care physicians are not required.
- The HDHP requires the annual deductible to be met before plan benefits are paid with the exception of preventive care.

Below is a brief comparison of all three of the District's medical plan options. Refer to the corresponding plan document at teampud.com/benefits for details.

ELECTRONIC EXPLANATION OF BENEFITS (EOB)
Premera members are automatically enrolled to receive electronic EOBs. Please log into your Premera account to view them.

PREMERA BLUE365 PROGRAM

- ***Available to PPO and HDHP members***
- ***Discounted programs partners with 100+ vendors to support health and wellness***
- ***No cost to members or plans***

From home, go to teampud.com/benefits, you may have to log in with your Microsoft credentials

Comparison of Medical Plan Options

IN = in-network provider; OON = out-of-network provider; family = 2 or more people covered

Benefit/ Provision	PPO Plan administered by Premera	HDHP (High Deductable Health Plan) administered by Premera	HMO Plan administered by Kaiser
Provider Choice	Your choice of IN provider Reduced benefits for OON providers	Your choice of IN provider Reduced benefits for OON providers	You must select a Kaiser provider or contracted provider
Network	Heritage www.premera.com/visitor/covered-drugs	Heritage www.premera.com/visitor/covered-drugs	Core healthy.kaiserpermanente.org/doctors-locations
Deductible	$250 per person/$750 per family (embedded*) Counts toward medical OOP maximum	$1,750 per person/$3,500 per family (aggregated**)	$100 per person/$300 family based on calendar year
Maximum Out- of-Pocket Copay	$1,850 per person/$5,550 per family	$3,500 per person/$7,000 per family based on calendar year Includes pharmacy (Rx)	$1,350 per person/$4,050 per family based on calendar year Includes pharmacy (Rx)
HSA District Contribution	N/A - not eligible for HSA employee or HSA District Contribution	$1,500 individual /$2,500 family (lump sum)	N/A - not eligible for HSA employee or HSA District Contribution
Telehealth & Virtual Care	$5 copay for in-network provider Telehealth: A visit with your provider Virtual Care: Transcarent for primary care and Spring Health for national behavioral health	Member pays full cost up to deductible Transcarent for primary care Spring Health for national behavioral health	$0 copay
Preventive Care	IN: 100% of allowable expenses, no deductible, no copay OON: 40% coinsurance of allowable expenses, no deductible, no copay	IN: 100% of allowable expenses, no deductible, no copay OON: 40% of allowable expenses, no deductible, no copay	Provided in full
Office Visits	IN: 100% after $20 copay OON: 40% of allowable expenses after deductible and $20 copay	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met	Primary care: $15 copay Specialty care: $20 copay
Alternative Care	Office Visit cost share applies: • Chiropractic (24 visits/year) • Acupuncture (24 visits/year) • Naturopathic & massage therapy (no limit)	Office Visit cost share applies: • Chiropractic (24 visits/year) • Acupuncture (24 visits/year) • Naturopathic & massage therapy (no limit)	Office Visit cost share applies Massage therapy is covered under the rehab/habilitation benefit and is only allowed when prescribed by a physician
Outpatient Services	IN: $50 copay + Deductible + 10% coinsurance OON: $50 copay + Deductible + 40% coinsurance	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met	$50 copay (per visit)
Inpatient Hospitalization	IN: $100 copay + Deductible + 10% coinsurance of allowable expenses OON: $100 copay + Deductible + 40% coinsurance	IN: 20% coinsurance after deductible met OON: 40% coinsurance after deductible is met	$100 copay (per admission)

***Embedded Deductible:** Each covered family member needs to reach the individual deductible until the family deductible has been met.*

For example: The subscriber has spent $250 in services, spouse $150 in services and child $50 in services.

The subscriber is only responsible for the copay and/or coinsurance amounts moving forwards. The spouse would need to another $100 and the child would also need another $200 in order to meet the $750 family deductible before the plan begins coverage.

***Aggregate Deductible:** The combined total of the family's expenses must meet the family deductible before the plan begins paying the coinsurance. If one member of the family has health care expenses high enough to meet the family's aggregate deductible, the plan will pay its share of expenses for the entire family.*

For example: The subscriber had spent $3,000 in services, spouse $300 and child $100 in services.

The deductible has been met and the plan pays for coinsurance for all family members.

Premera Resources

24-Hour Nurse & Online Services

All of the medical plans have resources available online and offer members a free 24-hour NurseLine/Consulting Nurse. PPO Plan members can enroll in free credit monitoring, view claims history and more. Visit www.premera.com for details.

Plan Network

Premera uses the Heritage network in Washington and Alaska. Services outside of Washington and Alaska can be accessed through the BlueCard PPO nation-wide provider network. These networks are very broad and comprehensive. Employees will receive the highest level of benefits if an in-network (IN) provider is used. An employee who utilizes an out-of-network (OON) provider will receive a lower level of benefits.

To find a network provider, visit www.premera.com and select "Find Care" and then "Find a Doctor." Under Employer-based plans, select "Browse all doctors and specialists" and then click "Choose a location and network." Enter "address, city, or zip code" and enter the network "Heritage." You can then search by location and specialty. You can also call Premera at 1-800-722-1471.

Telehealth

App-based visits using your cell phone or computer with your provider/clinic (i.e., Optum uses Vsee Clinic Mobile App).

Care:

- Primary Care - cold and flu, allergies, pink eye, sore throat, etc.
- Dermatology - rashes, acne, etc.
- Behavioral Health - anxiety / depression

Virtual care:

Premera partners with the following vendors for virtual care visits:

- **Transcarent** for general medical (primary & urgent care). Offers on-demand, text-first, or video for members age 1+. Learn more at www.premera.com/visitor/virtual-care.
- **Spring Health** for behavioral health services. Provides video and telephonic therapy for members age 6+. Pschiatry and medication management for members 18+.
- **Talkspace** offers text, audio, and video therapy for individuals age 13+, along with psychiatry and medication management for members 18+.

Kaiser Resources

24-Hour Nurse & Online Services

With the HMO Plan, members can look up benefits, refill prescriptions, complete a health profile and more. Visit www.kp.org/wa for details.

Plan Network

Kaiser provides care through its Core network of doctors and facilities. An employee must go to a Kaiser provider, or contracted provider, to receive benefits from the plan (other than emergency care). Kaiser also provides visiting member access to Kaiser facilities outside of Washington, including California, Colorado, District of Columbia, Hawaii, Georgia, Virginia and Oregon.

To find an in-network health care provider, visit www.kp.org/wa and click on "Find a Doctor." Under "Welcome, Visitor," select "Employer Plans" and select the "Core" network. You can then search by location and specialty. You can also call Kaiser at 1-888-901-4636 to find a provider.

Telehealth Virtual Office Visits

Visit options:

- 24/7/365 phone access to a licensed care provider for medical care and advice/urgent prescription refills at 1-800-297- 6877 or 206-630-2244 (TTY 711).
- Scheduled phone appointment with your current provider for health concerns that don't require an in-person visit or follow-up care after an in-office appointment.
- E-visit through completion of a short questionnaire for diagnosis/treatment for common conditions and prescriptions.
- 24/7 Care Chat with a provider to get immediate care, treatment, and prescriptions.
- Video visit with a provider the same day or next for a broad range of symptoms or health concerns for chronic conditions, follow-up care after an appointment, prescriptions, or lab test orders.

Visit wa.kaiserpermanente.org/html/public/get-care.

Prescription Drug Benefits

All of the District's medical plans provide prescription drug benefits. Below is a brief overview.

Comparison of Prescription Drug Benefits

Benefit/ Provision	PPO Plan administered by Premera	HDHP Plan administered by Premera	HMO Plan administered by Kaiser
Rx Out-of-Pocket Maximum	$1,100 individual/$3,300 family*	Included in medical maximum out-of- pocket expenses above	Included in medical maximum out-of-pocket expenses above
Drug List ("Formulary")	www.premera.com/visitor/covered-drugs • Drug list: Essentials 4-Tier (E4), Select "E1/E4" • Search for the medication name to find the Tier #1-4 or EX (Excluded) and Requirements/Limits	www.premera.com/visitor/covered-drugs • Drug list Essential 1-Tier, Select "E1/ E4" • Search for the medication name to find the Tier #1-4 or EX (Excluded) and Requirements/Limits	Large Employer with 3 Tiers for Core Network. To find out if a drug is in the HMO formulary, go to www .kp .org/wa, select "Get Care" and under Pharmacy, select "Drug Formulary." Under "Large Employer," select the "3-Tier In-Network Pharmacy Benefit."
Retail	Supply: Up to 30-day supply • Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $25 copay • Tier 3 See Specialty Rx below • Tier 4 Non-Preferred (generic/brand) - 30% coinsurance • Excluded - Not Covered*	Supply: Up to 90-day 20% coinsurance after deductible met	Supply: 90-day (Tier copay per 30-day) • Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $30 copay • Tier 3 Non-Preferred Generic/Brand - $50 copay
Mail Order	Supply: Up to 90-day supply • Preventive - $0 copay • Tier 1 Preferred Generic - $25 copay (2.5x retail) • Tier 2 Preferred Brand - $62.50 copay (2.5x retail) • Tier 3 See Specialty RX below • Tier 4 Non-Preferred (generic/brand) - 30% coinsurance • Excluded - Not Covered*	Supply: Up to 90-day 20% coinsurance after deductible met	Supply: 90-day supply • Tier 1 Preferred Generic -$20 copay • Tier 2 Preferred Brand - $60 copay • Tier 3 Non-Preferred Generic/Brand - $100 copay
Specialty Rx	Must be filled via mail order Accredo You or your doctor can call Accredo at 1-800-689-6592 Up to 30-day Supply Tier 3 Preferred Specialty - $45 copay Tier 4 Non-Preferred Specialty - 30% coinsurance	Supply: Up to 30-day 20% coinsurance after deductible met. You or your doctor can call Accredo at 1-800-689-6592	Supply: 30-day supply based on Retail tier copays above In some cases, refills can be mailed vs. picking up at a Kaiser pharmacy

**Excluded drugs (EX) do not apply to Rx OOP*



Dental

Employees have the flexibility to choose from two dental plan options:

- DPPO – provided by Delta Dental of Washington
- DEPO – provided by Willamette Dental Group

Benefit	DPPO provided by Delta Dental of WA	DEPO provided by Willamette Dental
Provider Choice	Choice of any licensed dentist. Benefit payment may vary depending on network: Premier, PPO or non-network dentist	You must select a participating clinic from Willamette Dental Group
Maximum Benefit Paid	$1,750 per year, per covered person	No limit
Deductible/Copay	No copays Class I Services: None Class II Services: None Class III Services: $50 person / $150 family per year*	No deductible • $10 copay per visit. Major dental work requires additional service copay • $30 specialty provider copay per visit
Preventive Care	Class I - Covered at 100%. Limited to twice in a calendar year.* Does not count towards Maximum Benefit Paid!	No additional copay
Filling	Class II - Covered at 80%. Deductible waived. Fillings based on resin allowable amount.	No additional copay
Crown	Class III - Covered at 80% after deductible met*	$250 service copay
Implants	Class III - Covered at 60% after deductible met*	Benefit maximum of $1,500 per calendar year
Orthodontia	$2,000 lifetime maximum benefit for adult and child	Interceptive and/or comprehensive treatment: Children and Adults: $1,500 copay
Invisalign®	$2,000 lifetime maximum benefit for adult and child	Invisalign copay applies in addition to orthodontia copay

**Applies to annual maximum benefit paid. Charges exceeding the annual maximum are the employee's responsibility.*

Please refer to the corresponding plan documents available at teampud.com/benefits, or contact the member services number listed at the back of this guide to inquire about specific benefits and treatments.

Networks

Listings of participating dentists and facilities are available for both plans.

Delta Dental (DPPO) Network

Employees can see any licensed dentist. Benefit payment may vary depending on network: Premier, PPO or non-network dentist. You may have lower costs if you see a dentist in the PPO Network. Search for a provider at www.deltadentalwa.com. Discount tickets, theme park, museum and more available for Delta Dental enrollees.

Willamette Dental (DEPO) Network

You must select a participating clinic from Willamette Dental Group. Search for providers and locations at www.willamettedental.com.



Coordination of Benefits

Coordination of Benefits (COB) is the process of coordinating health plan payments (including prescription drug payments) between two different medical and/or dental plans. A claim may be eligible for COB where an individual is enrolled in more than one health plan (typically an employee's medical/dental plan and a spouse/SRDP/domestic partner's medical/dental plan). The benefits must be payable under both plans and both plans must offer COB (some health care plans have limitations or restrictions on COB).

Employees who are cross-covered on their spouse/SRDP/ domestic partner's plan should keep in mind that they are primary on the plan they select and secondary on their spouse/ SRDP/ domestic partner's plan. Employees may want to check with their spouse's, SRDP's or domestic partner's insurer as to how that insurance carrier handles COB.

For COB of covered children, the general rule is that the plan of the parent with the birth date (month/day) falling first in the calendar year is the primary coverage.

See the corresponding plan document for details on COB rules.

Long-Term Disability (LTD)

LTD insurance administered by The Standard Insurance Company (The Standard) provides income protection for employees in the event of disability due to injury or illness sustained either on or off the job. An employee's LTD coverage level is based on regular monthly earnings in effect on the date of coverage, or Oct. 15 of the previous year, whichever is later.

Employees may be eligible to receive a monthly benefit of 50% of regular monthly earnings (to a maximum benefit of $10,000 per month) after a 90-calendar day waiting period is met. The monthly benefit is reduced by other sources of disability-related income (e.g., State Industrial, Occupational Disability Allowance, Sick Leave, Extended Sick Leave, Social Security Disability, Pension Disability, etc.) to a minimum benefit of $100 per month. However, if an employee is doing rehabilitative work, the total of earnings through the rehabilitative work and rehabilitative benefit cannot exceed 100% of their regular monthly earnings. This may result in a minimum benefit of less than $100.

Upon approval of an employee's claim, they are eligible for a "waiver-of-premium" beginning the first of the month following the claim effective date and for the remaining time they have an active LTD claim.

You are taxed on the Long Term Disability (LTD) premium, so that if/when you receive a LTD benefit payment, it will be tax-free to you! Paycheck code is "Long Term Imp." You will be taxed on the Earnings amount, but then the same amount will be reversed as a deduction.

Core Term Life

Core Term Life Insurance, administered by The Standard, provides a benefit to the employee's beneficiary(ies) upon their death.

An employee will have Core Term Life Insurance of 1x their base salary, rounded to the next $1,000, up to $300,000 (as of Oct. 15 of the previous year or as of hire date, excluding overtime (OT).

The IRS Group-Term life insurance code requires the Core Term Life coverage amount over $50,000 to be taxed based on your age as of January 1. The paycheck code is "Core Trm Imp." You will be taxed on the Earnings amount, but then the same amount will be reversed as a deduction.

The Core Term Life plan includes a terminal illness benefit (accelerated benefit) and a waiver-of-premium provision. The terminal illness benefit is 50% of an employee's Core Term Life Insurance coverage amount. At the time of an employee's death, the beneficiary will receive the remaining life insurance benefit.

The waiver-of-premium provision applies if an employee becomes totally disabled prior to age 60 and that disability lasts for six consecutive months. The Standard will continue insurance to age 70 or retirement (other than retirement due to disability), whichever occurs first, without further payment of premiums so long as total disability continues. This benefit is subject to proof of continuing disability each year.

The Core Term Life policy also includes seat belt, portability and conversion features.

Core Accidental Death & Dismemberment (AD&D)

Core AD&D, administered by The Standard, is protection that covers an employee in the event of accidental death or serious accidental injury.

This benefit is 100% paid by the District for the employee's life only, no medical questionnaire is required. The coverage is 1x the employee's base salary (excluding OT as of Oct. 15 of the previous year), rounded to the next $1,000, up to $300,000.

For more information, visit the Life Insurance section at teampud.com/benefits.

This section:
Vision • FSA • HSA

Optional Pre-Tax Benefits Choices

Vision

An employee and their dependents are eligible for vision insurance provided through EyeMed Vision Care which provides coverage for routine eye exam and pays for all or a portion of the cost of glasses and contact lenses. You can use out-of-network providers; however, you always save money if you stay in-network. You must spend your entire allowance in one purchase; any unspent balance of the allowance will be forfeited.

Explanation of Vision Benefits

Benefit	In-Network	Out-of-Network Reimbursement
Provider Choice	"Access" Network Retailers; Independent Provider Network + retailers including LensCrafters, Pearle Vision, Target Optical, Ray-ban.com, Glasses.com, ContactsDirect.com, Sunglass Hut, Oakley, and Oliver Peoples	
Frequency	Lenses/Frames AND contact lenses once/calendar year	
Eye Exam	$10 copay for eye exam at in-network provider, $0 cost preventive eye exam available at in-network providers on the medical plans	
Annual Allowance - Frames	$0 copay; $200 Allowance; 20% off balance over $200	Up to $100
Standard Plastic Lenses	Single vision/bifocal/trifocal/lenticular: $10 copay Standard progressive lens: $75 copay; premium progressive lens: $75 copay (80% of charge less $120 allowance)	Up to $25/$40/$55 Up to $40/$40
Lens Options	• UV treatment/tint (solid and gradient)/standard plastic scratch coating: $15 • Standard polycarbonate - adults/kids under 19: $40 • Standard anti-reflective coating: $45 • Polarized/other add-ons: 20% off retail price	N/A
Additional Pairs Benefit	40% discount off complete pair eyeglass purchases + 15% discount off conventional contact lenses once funded benefit has been used	N/A
Annual Allowances – Contact Lenses ***(includes materials only)***	• Conventional: $0 copay; $200 allowance; 15% off balance over $200 • Disposable: $0 copay; $200 allowance + balance over $200 • Medically Necessary: $0 copay, paid in full	Up to $160 Up to $160 Up to $210
Non-prescription Sunglasses – Sunglass Hut	Up to $50 off non-prescription sunglasses	N/A
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Hearing Care from Amplifon Network	Up to 66% off hearing aids	N/A

Glasses or Contact Lenses by Mail

You may order glasses or replacement contact lenses at competitive prices via the Internet and have them mailed directly to your home.

For contact lenses, this service is for replacement lenses only, and your core benefit allowance or discount will not apply to this service. Your initial pair of contact lenses must still be purchased from your eye care provider to ensure proper fit and follow-up care. Visit www.contactsdirect.com for details.

For glasses, visit www.glasses.com for details on purchasing online.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money – before it's taxed – through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have less income to be taxed!

IMPORTANT

Use it or lose it. Any money in an FSA that is not used for reimbursement of expenses incurred during the plan year (or grace period) will be forfeited.

Comparison of Flexible Spending Accounts

Plan	Annual maximum contribution	Examples of covered expenses
Health Care FSA	$3,400 (awaiting 2027 IRS limit)	Medical, dental, or vision costs including deductibles, copays, coinsurance amounts, and other non- covered health-care costs
Dependent Care FSA	$7,500 ($3,750 if married and filling separate tax returns, awaiting 2027 IRS limit)	Daycare centers, in-home childcare*, and before or after school care for your dependent children under age 13

**All caregivers must have a tax ID or Social Security number and must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine where you should enroll in this plan. You can set aside up to $7,500 per household for eligible dependent care expenses for the year.*

Your FSA elections are effective from Jan. 1, 2027 to Dec. 31, 2027. Claims for reimbursement must be incurred by Dec. 31, 2027, for the Dependent Care FSA and submitted by March 31, 2028. The Health Care FSA has a Grace Period. If a balance is remaining in your Health Care FSA on Dec. 31, you can incur new expenses through March 15, 2028, to use any remaining FSA funds from the 2027 plan year. You must submit reimbursement to ThrivePass by March 31, 2028. Plan your contributions carefully. Any money remaining in your account after March 31, 2028, will be forfeited.

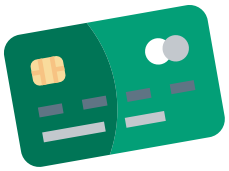
Claims Substantiation

The IRS requires you to retain all documentation/proof (such as Explanation of Benefits or itemized statement from the provider/merchant) of FSA debit card charges to substanti- ate eligible FSA expenses. Documentation for substantiation can be submitted via the ThrivePass website, mobile app, fax, email, or mail.

HEALTHCARE FSA GRACE PERIOD

If you have a remaining balance in your healthcare FSA as of Dec. 31, you can incur new expenses through March 15 of the following year to use any remaining FSA funds from the prior year. You must submit reimbursement to ThrivePass by March 31.

ThrivePass FSA Debit Card Substantiation



The debit card may be a convenient way to pay for your qualified health expenses (paid directly from your FSA account). The IRS requires you to retain all documentation/proof of debit card charges with your tax documents so you can substantiate your eligible expenses.

In most cases, you may need to provide documentation to verify debit card charges were for eligible expenses. Preferred documentation is an Explanation of Benefits (EOB) because it includes all the information the IRS requires. If an EOB is not applicable/available, submit an itemized statement from the provider/merchant. Some examples of unacceptable documentation are credit card receipts/statement, cash register receipts, and canceled checks.

Documentation for substantiation can be submitted several ways:

Web: Log in to app.thrivepass.com and navigate to my accounts, then upload receipts

Mobile App: Install "ThrivePass Pre-Tax Accounts" App, log in and tap "claims" to review list of your pending claims and attach your documentation.

Email: tpa@thrivepass.com

Mail: P.O. Box 220 Minneapolis, MN 55440

Fax: 1-888-265-5413

Claims documentation must include five key things:

1. Date of service
2. Who the expense is for (self, spouse, etc.)
3. Provider name (i.e. Medicare, CVS, etc.)
4. Type of service (i.e., premium, Rx, copay, etc.)
5. Dollar amount



Debit card transaction/substantiation timeline

- **Day 1** – The participant swipes the debit card and substantiation is needed. The card swipe will display in the 'New' status in the 'Transaction History,' within the participant portal, and mobile app.
- **Day 45** – ThrivePass emails (or mails if no email is on file) a letter to the participant showing all the information about the card swipe and the information needed to substantiate the transaction. The card swipe will display in a 'Pending' status in the 'Transaction History,' within the participant portal, and mobile app.
- **Day 75** – ThrivePass emails (or mails if no email is on file) a second reminder letter requesting the same information.
- **Day 90** – ThrivePass emails an ineligible letter alerting the participant that their card is temporarily suspended. At that time, the card swipe moves to an 'Ineligible' status and shows as a 'Balance Due.' The debit card is suspended until the transaction is resolved (per IRS rules).



Health Savings Account (HSA)

A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified health expenses. This type of account offers a triple tax savings (no taxes on employee or employer contributions, investment earnings, and withdrawals). You must be enrolled in the District's High Deductible Health Plan to be eligible to enroll in the HSA.

The District provides the following HSA contribution based on HDHP Coverage Level in an annual lump sum:

- Individual: $1,500
- Family: $2,500

The IRS sets the annual HSA contribution limit (employee + employer). The unused account balance at year end rolls over, it is not forfeited.

You are ineligible for employee & employer HSA contributions if you have other types of medical coverage, such as:

- Full-purpose Health Care FSA or HRA (regardless of balance) under your own, spouses' or parent's plan
- Major medical plan (i.e., PPO, HMO) under a spouses' or parent's plan
- Tricare or Medicare (not eligible to make HSA contribution 6-months prior to applying for Medicare)

Comparison of HCFSA and HSA

	HCFSA	HSA
Medical Plan	PPO or HMO	Qualified High Deductible Health Plan (HDHP)
Unused Balance	Use it or lose it with a Grace Period*	Rollover year-to-year
Dependent Reimbursement Eligibility	Tax dependents (spouse, child under age 19, etc.), adult children up to age 26	Tax dependents only (spouse, children under age 19, or under age 24 if full-time student)
Contribution Sources	Employee only	Employee, employer, and any individual (directly into HSA)
Contribution Limit (2027)	$3,400 (awaiting 2027 IRS limit)	Individual $4,500, Family (2+) $9,000 (age 55+ additional $1k)
Investments	None	Account balances $1,000+ (no tax on investment earnings)
Reimbursement Maximum	Up to annual election	Up to account balance
Roll-in Allowed	N/A	Yes
Debit Card	Yes	Yes
Qualified Expenses	IRS Publication 502 (www.irs.gov/forms-pubs/about-publication-502)	IRS Publication 502 (www.irs.gov/forms-pubs/about-publication-502) Insurance premiums [Long-Term care, COBRA, Medi- care (Medigap not eligible)]
Non-qualified Expenses	N/A	Non-qualified distributions are allowed, but are subject to income tax + 20% penalty (if under age 65)

**Annual HCFSA Grace Period: If an unused HCFSA balance remains at year end, additional FSA expenses can be incurred through March 15 of following year, but must be submitted to ThrivePass by March 31.*

This section:
Voluntary AD&D • VTL Employee • VTL Spouse • VTL Child

Optional After-Tax Benefits Choices

Voluntary Accidental Death & Dismemberment (AD&D)

Voluntary AD&D coverage, administered by The Standard, is additional protection that covers an employee and their family in the event of accidental death or serious accidental injury.

The AD&D plan includes a waiver of premium provision. For more information, visit the Life Insurance section at teampud.com/benefits.

Employees may select this optional benefit in increments from $25,000 to $250,000 for "Employee Only" or "Family Plan" coverage. Under the Family Plan, dependent coverage amounts are equal to the following percentages of the coverage the employee has chosen for himself/herself:

- **At time of loss, the family consisted of employee, spouse or SRDP, and dependent child(ren):**
  - Employee 100%
  - Spouse/SRDP..... 40%
  - Each child..... 10%
- **At time of loss, the family consists of employee and spouse or SRDP but NO dependent child(ren):**
  - Employee 100%
  - Spouse/SRDP..... 50%
- **At time of loss, the family consists of employee and dependent child(ren) but NO spouse or SRDP:**
  - Employee 100%
  - Each child..... 15%

What is Covered

Depending on the type of accidental loss or injury, this policy pays up to 100% of the benefit amount the employee has chosen. Coverage includes the following benefit levels:

- Loss of life..... 100%
- Loss of both eyes..... 100%
- Loss of two limbs (hand/foot) ... 100%
- Paraplegia..... 75%
- Loss of one limb (hand/foot) 50%

This benefit also includes a seat belt and air bag provision that would pay an additional benefit in the event of death as a result of an auto accident.

What is Not Covered

Plan benefits are not payable if a loss results from, or is caused by, self-inflicted injuries or suicide; any felony committed by the insured; any act of war; sickness, disease, physical or mental impairment; bacterial or viral infection regardless of how it was contracted; and any medical or surgical treatment for any of the above.

Benefits are also not payable under certain other circumstances, such as while you are on full-time active duty in the armed forces or traveling in an aircraft that is owned, leased or controlled by the District.

ADDITIONAL INFORMATION
Refer to the policy information located at teampud.com/benefits**.**

IMPORTANT

No one may be covered more than once under the Voluntary AD&D/VTL plan. If covered as an employee, an employee cannot also be covered as a spouse, SRDP or dependent child.

Voluntary Term Life (VTL)

Voluntary Term Life (VTL), administered by The Standard, provides voluntary term life insurance upon the death of an enrolled employee, their spouse or SRDP, and/or dependent children, including dependent children of the employee's SRDP.

The VTL plan includes a terminal illness benefit and a waiver-of-premium provision. For more information, visit the Life Insurance section at teampud.com/benefits.

Guaranteed Issue

Guaranteed issue (GI) is a specific amount of insurance coverage available to all newly-eligible employees and spouses/SRDPs that is not subject to medical underwriting or approval by The Standard.

Coverage requested over this guaranteed issue for both employee and spouse or SRDP is subject to medical underwriting and approval by The Standard and requires the employee to submit evidence of insurability (EOI).

EOI must be submitted to The Standard within 60 days of electing coverage over the guaranteed issue. Coverage amounts requiring submittal of EOI will become effective the first of the month following receipt of The Standard's approval.

EOI is available at teampud.com/benefits or by contacting Human Resources. Failure to submit the EOI to The Standard will limit the maximum coverage to the guaranteed issue amount.

VTL Employee

VTL is available to employees in $10,000 increments. Coverage can be up to 5 times base salary not to exceed $750,000.

During an initial enrollment period, a newly-eligible employee may elect up to the GI amount of $200,000 without needing to submit an EOI to The Standard.

Employees may request new or higher coverage during a Life Event or Open Enrollment period, but will be subject to medical underwriting and required to submit EOI to The Standard.

SMOKER STATUS

Defined as the use of any form of tobacco in the last 12 months.

VTL Spouse/SRDP

To cover a legal spouse or SRDP, an employee must be enrolled in VTL employee coverage. An employee may elect coverage for their spouse/SRDP in $10,000 increments with a minimum of $10,000 up to a maximum of $250,000, not to exceed 100% of the employee's approved coverage amount.

A newly-eligible spouse or SRDP is eligible for the guaranteed issue amount of $30,000, not to exceed 100% of the employee's approved coverage amount. Amounts over the guaranteed issue require EOI approval and will become effective the first of the month following receipt of The Standard's approval.

VTL Child

If you are enrolled in VTL employee coverage, you may elect $10,000 of coverage for your dependent children (see the "Dependent Eligibility" section of this guide). The maximum benefit for children under six months of age is $500.

PREMIUM CALCULATIONS

Premiums for an employee, their spouse or SRDP are calculated based upon that individual's age as of Jan. 1 and smoker status. To calculate the monthly premium for an employee/spouse or SRDP: Take your level of coverage ÷ $1,000 x premium rate (age as of Jan. 1, 2027) = total monthly premium. Note: Premium rates can be found on page 31 of this guide. One monthly premium will insure all of the employee's eligible children, regardless of the number of children covered.

Supplemental Voluntary Benefits

Medical insurance may not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible or coinsurance of a major medical event. Voluntary Benefits, administered by Securian, can help cover expenses that major medical does not cover. Three options are available: Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefits even if you have other insurance.

Please note these plans don't replace medical insurance and do not satisfy the requirements of minimum essential coverage under the Affordable Care Act (ACA).

Visit securian.com/pud-insurance for additional information, rates, and plan summaries.

Critical Illness Insurance

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. The benefit amount is based on the coverage level you elect between $10,000 to $40,000 in $10,000 increments.

This insurance may pay benefits regardless whether the medical condition is work related or not, provided all policy definitions are met.

Example of covered illness: heart attack, type 1 Diabetes, cancer, Autism, stroke, and infertility.

Plan Features

- No health exam or questions required to purchase critical illness insurance
- You can elect to cover your Spouse/SRDP and children
- No exclusions for pre-existing health conditions, but covered diagnoses must occur after the coverage effective date

Accident Insurance

Accidents happen! You can't always prevent them, but you can take steps to reduce the financial impact of bills and expenses that may not be covered by your medical and disability insurance. Accident insurance offers additional financial protection by providing a cash payment directly to you if an accident occurs

The Plan covers a wide variety of injuries and accident-related expenses such as: fractures resulting from child and adult organized sports, emergency room treatment, follow-up care, dislocations, and surgery.

This insurance is designed to cover off-the-job events and does not provide benefits for injuries sustained in the course and scope of employment.

Plan Features

- You can elect to cover your spouse/SRDP and children
- No health exam or questions required to purchase accident insurance
- Cash payments paid directly to you to use for medical and non-medical expenses
- Cash payment for burns, dislocation/fracture requiring surgery, concussions, coma, organized sports injuries, x-ray, ER treatment, urgent care visit, emergency dental, injuries, anesthesia and follow up care. Adapative home and vehicle.

Hospital Indemnity Insurance

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to pile up. Hospital Indemnity Insurance pays a lump sum benefit directly to you if you are admitted into a hospital for care due to illness or injury.

This insurance is designed to cover off-the-job events and does not provide benefits for injuries sustained in the course and scope of employment.

You receive a benefit for the following: admission benefit, hospital confinement, and intensive care unit.

Plan Features

- You can elect to cover your spouse/SRDP and children
- Ability to submit labor and delivery claim ahead of hospital stay at 36 weeks pregnant
- No health exam or questions required to purchase hospital indemnity insurance
- Payments available for inpatient mental health stay and outpatient mental health and substance use screenings
- Can be used for planned and unplanned hospitalizations

HEALTH SCREENING BENEFIT

You, your spouse/SRDP and child(ren) are each eligible for a $50 health screening payment each year when enrolled in accident and/or hospital indemnity insurance. Get cash payments for preventative care and other health screenings, including an annual physical exam.

Each insured may receive a maximum of one health screening benefit payment each plan year per plan. If you are enrolled in multiple plans, you may be eligible to receive multiple payments.

This section:
Employee Assistance Program (EAP) • Tuition Reimbursement • Retirement Health Savings (RHS)

Additional Benefits



Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is available to all District employees, household members, and dependent children. The District's EAP offers up to five (5) sessions per family member/per incident, each calendar year. EAP services are provided by SupportLinc EAP.

The EAP provides short-term, confidential counseling for you and your family at no out-of-pocket expense to you. EAP therapists can provide assistance with issues related to:

- Stress
- Abuse
- Marriage
- Finances
- Relationships
- Parenting
- Grief
- Work
- Depression
- Retirement
- Free legal consultation & discounted legal referrals

All discussions between you and the EAP therapist are confidential. Personal information is never shared with anyone, including the District, at any time without your direct knowledge and approval. (Exceptions are made only in cases governed by law to protect individuals threatened by violence.)

SupportLinc EAP

1-800-553-7798

supportlinc.com

On first visit enter code: snohomishcountypud
(no spaces, not case sensitive) to create an account

Tuition Reimbursement

The district offers educational assistance to full-time employees enrolled in formal degree or certificate programs or approved individual courses. Participation is voluntary, and courses must be taken outside of work hours. Reimbursement up to $5,250 per calendar year.

Retirement Health Savings (RHS)

All regular (represented and non-represented) employees hired/rehired, on or after July 1, 2009, are eligible for the Retirement Health Savings (RHS) Plan. The RHS plan, also known as a Health Reimbursement Arrangement, is a way for you to pay for future health care costs. The RHS Plan is tax-advantaged (i.e., pre-tax contributions, tax deferred earnings and withdrawals) and has investment options.

Employee (represented & non-represented) who have 1 paid hour in a month receive a monthly District contribution (outlined in CBA 5.11.6.1) into the RHS account. The RHS account/monies can't be withdrawn while employed at the District. Upon separation or retirement, the RHS account may be used to request reimbursement for qualified out-of- pocket health-care expenses, including premiums.

The RHS plan (Plan #803083) is administered by MissionSquare Retirement. Log into MissionSquare Retirement Account Access (same login as 401(k) and 457 plans) at www.missionsquare.com to access the RHS account (i.e. balance, in- vestment funds, etc.)

SURVIVORS
Add a survivor to your RHS plan at
www.missionsquare.com.

Gym Discounts

A gym membership discount program is available to support your wellness goals. Through Active&Fit Direct, you'll gain access to thousands of fitness centers at a lower cost with no enrollment fee, and more. For more information, visit teampud.com/gymdiscount.

Savings & Retirement

PLANNING TO RETIRE?
Check out the "Countdown to Retirement" brochure at teampud.com/retirement.

Retirement Plan

Snohomish County PUD is not a Social-Security-covered employer; new employees participate in the Medicare portion of Social Security only.

Eligible employees* of the PUD are enrolled as members of the Washington State Public Employees' Retirement System (PERS) administered by the Department of Retirement Systems (DRS) in one of the following plans:

- PERS Plan 2
- PERS Plan 3

Both the District and the employee contribute to PERS.

**If receiving a retirement benefit, employees may not be eligible to participate in PERS.*

New Employees to PERS

To learn about the differences between PERS 2 and PERS 3, visit the "Choose a plan" page at www.drs.wa.gov/choice.

- You have 90 days to choose either PERS 2 or PERS 3, it's a permanent decision. Completed Member Information Form (MIF) should be returned via interoffice mail to Human Resources, mailstop E2.
- PERS 2 is the default plan.
- Create/login DRS Account www.drs.wa.gov/account/
  - › Review service credit balance
  - › Estimate your retirement benefit
  - › Update beneficiaries

Webinars (live & recorded): www.drs.wa.gov/webinars/ Choosing a plan (Plan 2 or Plan 3), getting ready for retirement, early retirement, benefit options at retirement, Medicare, etc.

For general information about the PERS plans, visit www.drs.wa.gov, under Plans, select PERS Plan 2 or PERS Plan 3.

Note: the District does not participate in the DRS Deferred Compensation Program (DCP) or the Public Employees Benefits Board (PEBB).

Retirement Savings/ Deferred Compensation

The District offers two deferred compensation plans: a 457 Deferred Compensation Plan and a 401(k) Savings Plan. Employees can make contributions on either a pre-tax and/or a Roth (after-tax) basis. See table below for a 401(k) and 457 plan overview. Scan the QR Code to create your online credentials and start participating in the retirement plan.

401(k) Employer Match

The PUD will provide a pre-tax match equal to 100% of an employee's pre-tax and Roth 401(k) contributions, up to the first 4.5% of the employee's eligible wages. You must contribute 4.5% or a dollar amount equivalent to 4.5% to receive the full employer match contribution each pay period. The 401(k) employer match contribution will be made on a pre-tax basis, even if the employee is only making Roth (after-tax) contributions. The PUD's 401(k) matching contribution is vested after three years of employment.

MissionSquare administers both the 401(k) and 457 plans. To enroll or change your contributions, go to www.missionsquare.com and set-up/login to Account Access.

When will my enrollment/change take effect?

401(k) / 457 new enrollments/re-enrollments and deferral changes will be effective the first of the next pay period (or as soon as administratively feasible).

Want to roll over money? You can roll over your retirement savings from a previous plan by logging into Account Access. Contact our Retirement Plans Specialist for details.

Visit the MissionSquare website for education, financial planning webinars, to schedule an appointment with our Retirement Plans Specialist, complete a financial plan, and much more!

MissionSquare: www.missionsquare.com
800-669-7400

Retirement Plans Specialist – Sonia Rogers
sorogers@missionsquare.com, 202-759-7143

Certified Financial Planner – Keith Penewit
kpenewit@missionsquare.com, 202-759-7015

Below is a comparison chart to show the differences.

Comparison of the 457 and 401(k) Plans

	457 Plan	401(k) Plan
Plan number	306931	106638
Annual contribution limit (combined pre-tax & Roth)	100% of adjusted gross income[1], not to exceed a maximum of $24,500 (awaiting 2027 IRS limit)	99% of adjusted gross income[1], not to exceed a maximum of $24,500 (awaiting 2027 IRS limit)
Pre-tax employer match (pre-tax and/or Roth contributions)	N/A	Yes 100% of employee's elective contributions, up to the first 4.5% of an employee's eligible wages[2]
Catch-up: Age 50+/60-63	Additional Contributions: $8,000/$11,250 (awaiting 2027 IRS limit)	Additional contributions: $8,000/$11,250 (awaiting 2027 IRS limit)
457 double catch-up (age 59 or older)	Additional $24,500 catch-up contributions for 3 tax years prior to the year of full retirement age (unreduced PERS benefit)[3]	N/A
Vesting	Fully vested	Employee contributions: Fully Vested Employer contributions: Vested after 3 years of employment
Inservice withdrawal options (pre-tax & Roth)	• Pre-tax: Age 59 ½ no penalty • Unforeseeable emergency • Roth: 59 1/2 & 5+ yrs contributions & earnings tax free • Withdrawal of rollover monies • Domestic abuse victims, qualified federal declared disasters and birth/adoption	• Hardship withdrawal • Pre-tax: Age 59 ½ no penalty • Roth: 59 1/2 & 5+ yrs Contributions & earnings tax free • Withdrawal of rollover monies • Domestic abuse victims, qualified federal declared disasters and birth/adoption
Loan provisions (pre-tax only)	N/A	Loans up to $50k or 50% of balance
Distribution options upon separation from service	Lump sum, systematic payments (i.e., monthly, quarterly, etc.)	
Withdrawal from Pre-Tax assets upon separation from service	Any age - no early withdrawal tax	• Less than age 59 ½ – subject to 10% early withdrawal penalty, except if an employee separates from service during or after the year employee turns age 55 • After age 59 ½ – no early withdrawal penalty
Withdrawal from Roth assets upon separation from service	Roth withdrawals taken on a pro-rated basis between (nontaxable) Roth contributions and Roth earnings. Tax-free withdrawals if: • You're age 59 ½ or older *(or disabled or deceased) AND • At least 5 years have passed since Jan. 1 of the year of your first Roth Contribution If criteria is not met, Roth earnings are taxable & you may incur a 10% early withdrawal penalty. Exception: No penalty if you separate from service during or after the year you turn age 55.	
Required minimum distributions (RMDs)	Roth – Not applicable Pre-tax: At least age 73 or separation from service, whichever is later	Roth – Not applicable Pre-tax: At least age 73 or separation from service, whichever is later
Eligible prior plan rollovers	Pre-tax or Roth 457	Pre-tax or Roth 401(k), 401(a), 403(a), 403(b), Traditional IRA 408 (a) or (b)

1 Adjusted gross income = Gross Earnings, minus pre-tax benefit deductions (medical, dental, vision, FSA, HSA) and PERS, not to exceed $360,000 (awaiting 2027 IRS limit)*

*2 Eligible wages – W2 wages, including OT and bonuses, not to exceed $360,000** (awaiting 2027 IRS limit). *Refer to 401(k) plan document Section 2.10*

3 Subject to certain limitations

This section:
Medicare Part D Disclosure Notice • Notice of Availability of Privacy Practices • Women's Health & Cancer Rights Enrollment Notice • Newborns' and Mothers' Health Protection Act Disclosure • Premium Assistance Under Medicaid and the Children's Health Insurance Program • USERRA • HIPAA Special Enrollment Rights Notice • No Surprises Act Notice • Patient Protection Notice

Legal Information and Notices

Medicare Part D Disclosure Notice

Important Notice from PUD #1 of Snohomish County About Your Prescription Drug Coverage and Medicare

This Notice is for employees and their dependents who are eligible for Medicare or who will be eligible for Medicare in the next 12 months. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PUD #1 of Snohomish County ("the District") 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 is available 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. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. In general, Medicare Part D provides coverage for prescription drugs not covered under Medicare Part A and Part B. 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. The District has determined that the prescription drug coverage offered by the District's medical plans (PPO Plan, HDHP and the HMO Plan) are, 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 enrolled in Medicare Parts A and/or B and each year during the Medicare Part D open enrollment period from Oct. 15 to Dec. 7 (with coverage beginning the following Jan. 1).

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

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

If you decide to join a Medicare drug plan, your current District coverage will not be affected. However, the coverage provided by the District coverage will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. The coverage provided by the District Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced.

Full-Time employees are not able to drop District coverage. However, if you are a dependent of a District employee and you decide to join a Medicare drug plan and your District coverage is dropped, be aware that you will not be able to rejoin a District plan until the next open enrollment period or the next time you have a qualifying life event allowing you to rejoin the District coverage.

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 the District 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 Medicare Part D open enrollment period to join.

Prescription Drug Copays

PPO Plan	HMO Plan	HDHP
Participating pharmacy (up to 30-day supply*): • Preventive - $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $25 copay • Tier 3 Preferred Specialty* - $45 copay • Tier 4 Non-Preferred (generic/brand/specialty*) – 30% coinsurance • Excluded – Not Covered Mail order (up to 90-day supply*): • Preventive - $0 copay • Tier 1 Preferred Generic - $25 copay (2.5x retail) • Tier 2 Preferred Brand - $62.50 copay (2.5x retail) • Tier 3 Preferred Specialty* - $45 copay • Tier 4 Non-Preferred (generic/brand/specialty*) – 30% coinsurance • Excluded – Not Covered	Retail Supply: 90-day (Tier copay per 30-day): • Preventive: $0 copay • Tier 1 Preferred Generic - $10 copay • Tier 2 Preferred Brand - $30 copay • Tier 3 Non-Preferred Generic/ Brand - $50 copay Mail order (90-day supply): • Tier 1 Preferred Generic -$20 copay • Tier 2 Preferred Brand - $60 copay • Tier 3 Non-Preferred Generic/ Brand - $100 copay	• Retail (up to 90-day supply) – 20% coinsurance after deductible is met • Mail Order (up to 90-day supply) – 20% coinsurance after deductible is met • Specialty Rx* (Up to 30-day supply) 20% coinsurance after deductible is met

**PPO & HDHP Specialty Rx have quantity limits and must be filled via Accredo mail order.*

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

Contact Human Resources for further information at (425) 783-8557. 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 the District 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 www.medicare.gov/medicare-you-handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Oct. 1, 2026
PUD #1 of Snohomish County, Human Resources
PO Box 1107, Everett, WA 98206-1107
425-783-8557
hrbenefits@snopud.com

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).

Notice of Availability of Privacy Practices

The Snohomish County PUD Group Health Plans offered under its Employee Health Benefits Program (the Plan) maintain a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, go to teampud.com/benefits and click on "Important Documents & Notices."

Women's Health & Cancer Rights Enrollment Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact Human Resources at 425-783-8557 or email hrbenefits@snopud.com for more information.

Newborns' and Mothers' Health Protection Act Disclosure

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/
916-445-8322
Fax: 916-440-5676
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
1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
1-855-692-6442

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

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

ILLINOIS - Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid application
https://abe.illinois.gov
217-524-8268
mhfs.boc.hipp@illinois.gov

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid

https://www.in.gov/medicaid/
Family and Social Services Administration
http://www.in.gov/fssa/dfr/
1-800-403-0864
Member Services: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid:
https://hhs.iowa.gov/medicaid
1-800-338-8366
Hawki:
https://hhs.iowa.gov/medicaid/plans-programs/hawki
1-800-257-8563
HIPP:
https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
1-888-346-9562

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

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

LOUISIANA – Medicaid
Louisiana Medicaid:
https://www.ldh.la.gov/healthy-louisiana
1-888-342-6207
healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP):
https://www.ldh.la.gov/lahipp
1-877-697-6703
La.HIPP@la.gov
Fax: 1-888-716-9787
Mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
1-800-442-6003, TTY: Maine relay 711
Private Health Insurance Premium:
https://www.maine.gov/dhhs/ofi/applications-forms
1-800-977-6740, TTY: Maine relay 711

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

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/
1-800-657-3672

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

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

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

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

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

NEW JERSEY – Medicaid and CHIP
https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/
1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

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

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

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

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

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

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/
upp@utah.gov
1-888-222-2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

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

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

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

WEST VIRGINIA – Medicaid and CHIP
https://bms.wv.gov/
http://mywvhipp.com/
Medicaid: 304-558-1700
CHIP Toll-free: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

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

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent.

If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the Leaves Team at hrleaves@snopud.com or 425-783-8655 for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

HIPAA Special Enrollment Rights Notice

A federal law called HIPAA requires that we notify you of your right to enroll in the District's group health plan under the plan's special enrollment provisions if you acquire a new dependent, or if you decline coverage under the District's plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

If you declined enrollment for the District's medical, vision or dental benefits for yourself or your eligible dependents because of other health, vision or dental insurance or group health plan coverage, you may be able to enroll yourself and/or your eligible dependents in, or change your coverage under, the medical, vision or dental benefits provided by the District if coverage under the other plan is lost due to one of the following:

- Loss of eligibility for coverage under the other plan for reasons including, but not limited to, termination of employment, divorce, death, loss of dependent status or a reduction in hours that affected plan eligibility;
- Coverage ended because you or your dependents no longer live or work in the other plan's service area;
- Employer contributions to the other plan stopped;
- The other plan was terminated or discontinued; or
- COBRA coverage under the other plan ended.

However, you must request enrollment in or a change under the District's plan within 30 days after your or your dependents' other plan coverage ends for one of these listed reasons. Changes are effective the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month

In addition, if you have a new dependent as a result of marriage or commencement of State Registered Domestic Partnership, you may enroll in or change coverage for yourself, your spouse or Domestic Partner and/or dependent children. However, you must request enrollment or a change within 30 days after the marriage or commencement of the State Registered Domestic Partnership . Coverage is effective as of the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month. For example, you get married on May 1 and the District receives your request to add your new spouse to coverage on May 15. The coverage for your new spouse will be effective June 1.

In addition, if you have a new dependent as a result of birth, adoption, or placement for adoption, you may enroll, or change coverage for, yourself, your spouse or State Registered Domestic Partner and/or your dependent children. However, you must request enrollment or a change within 60 days after the birth, adoption, or placement for adoption. The new coverage will be effective as of the date of the birth, adoption or placement for adoption.

The District also allows a HIPAA special enrollment for eligible employees and eligible dependents who are not enrolled in the District coverage if (1) they lose Medicaid or CHIP coverage because they are no longer eligible for Medicaid or CHIP: or (2) if they become eligible for a state's Medicaid or CHIP premium assistance program under which the program will pay some or all of the premiums for coverage under Plans. Employees have

60 days from the date of the Medicaid/CHIP event to request enrollment under the District's plans. Changes are effective the first of the month following receipt of your request for coverage, or coincident with the date your request is received, if it is on the first of the month.

Please note that special enrollment rights will be extended only if you notify the District within 30 days or 60 days (as indicated above) of the event.

You may also be allowed to enroll in or change coverage under the plan outside of the District's open enrollment period in other situations. Please see the Benefits Booklets for your group health plan benefits or the Employee Health Benefits Program document for more information.

No Surprises Act Notice

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal and state law from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with Premera (or a contract with another Blue Cross and/or Blue Shield licensee) or Kaiser to provide services for your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Washington state law and your Premera or Kaiser health coverage also protect you from balance billing for emergency care from an out-of-network hospital in Washington, Oregon and Idaho, and from an out-of-network provider that works at the hospital. If you have made an overpayment for such emergency care, the provider must refund the overpayment within 30 business days after the provider received it. For more information, please see the Consumer Rights Notice under the Balance Billing Protection Act, available at:

www.insurance.wa.gov/protections-surprise-medical-billing

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Washington state law and your Premera or Kaiser health coverage also protect you from balance billing for the following services by an out-of-network provider at an in-network hospital or outpatient surgery center in Washington: surgery, anesthesia, pathology, radiology, laboratory and hospitalist care. If you made an overpayment for such services, the provider must refund the overpayment within 30 business day after the provider received it. For more information, please see your benefit booklet and the Consumer Rights Notice under the Balance Billing Protection Act, available at

www.insurance.wa.gov/sites/default/files/documents/final-consumer-notice-of-surprise-billing-rights_0.pdf

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact Premera or Kaiser, the Department of Labor, CMS or your medical provider.

Visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law. More information about your rights under Washington law is available at www.insurance.wa.gov/surprise-billing-and-balance-billing-protection-act. For information on how these protections apply to your Premera coverage or if you have questions on a specific claim, please contact Premera at 1-800-722-1471 or www.premera.com. For information on how these protections apply to your Kaiser coverage or if you have questions on a specific claims, please contact Kaiser at 1-206-630-4636 or 1-888-901-4636 or www.kp.org/wa.

Patient Protection Notice

Premera and Kaiser Permanente generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Premera at www.premera.com/visitor or Kaiser Permanente at www.kp.org/wa.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Premera or Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Premera at www.premera.com/visitor or Kaiser Permanente at www.kp.org/wa.

Benefit Definitions

Allowed Amount aka *Allowable Charges, usual, customary, and reasonable:* The highest amount that a contracted or in-network provider is allowed to charge for a service. In-network providers that charge over the allowed amount are required to write-off or not bill the patient. If the plan does not have a contract with the healthcare provider, this is the dollar amount considered by a health insurance plan to be a reasonable charge for medical services or supplies based on the rates in your area. See *Out-of-Network* definition.

Balance Billing: Amount billed in excess of the allowed amount. Out-of-network providers aren't subject to allowed amounts and can bill the patient for charges over the allowed. See *Out-of-Network* definition.

> **Example 1 - No balance billing:** John goes to in see an in-network facility for a $1,000 billed procedure. The allowed amount is $750, so the facility writes off the difference of $250. John pays his $250 deductible and also 10% coinsurance of the $500 ($50) that's left. The insurance company pays $450 to the facility and total cost to John is $300. (Deductible plus coinsurance).
>
> **Example 2 - Balance billing: John goes to an out-of-network facility. They also bill $1,000 for the procedure. The allowable charge is still $750. Since the facility doesn't have to go by the allowable charge, John pays the $250 difference (balance billed charge), as well as his deductible of $250 and higher 40% coinsurance. Total cost to John is $700. (Deductible plus co-insurance plus balance billed charge).**

Brand Drug: When a drug is initially developed, the pharmaceutical company is granted a patent on the drug for a period of 20 years (brand drug). During the life of the patent, no other manufacturer is allowed to produce or sell the same drug product without the patent holder's approval, thus eliminating direct price competition. See *Formulary* definition.

Coinsurance: The percentage share payable by the member of the allowed amount, after the deductible is paid. *Example:* If the member has a 10% coinsurance for inpatient hospitalization, plan pays 90% and the member pays 10%.

Coordination of Benefits (COB): Coordination between insurance carriers to determine who pays first, second, or third when 2 or more health insurance plans are responsible for paying the same medical claim. Coordination of benefits are also used to make sure that reimbursements are not higher than billed charges.

Copay: A fixed amount due at the time of service, which the member is required to pay for certain services and supplies provided under the plan. A member is responsible for the payment of a copay directly to the provider of the service or supply. *Example:* If the plan has a $20 copay for office visits, the member would pay $20 to their provider directly.

Cost Share: Member portion (i.e., copay, coinsurance, etc.)

Coverage Level: A term to identify who is covered on a plan, typically medical, dental and vision plans (i.e., employee only, employee + spouse, employee + child(ren), employee + family).

Deductible: The amount a member must pay and satisfy before the insurance company starts to pay. Once a deductible is met, most benefits apply coinsurance.

Formulary: A list of prescription drugs established by the insurance company, Third Party Administrator (TPA), and/or Pharmacy Benefit Manager (PBM) that has been created to represent drugs in each therapeutic class that represent the best combination of cost and effectiveness. Also, see *Tiered Benefit, Brand Drug* and *Generic Drug* definitions.

Fully Insured: An insurance company assumes all liability for claims paid. The employer agrees to pay premium payments to the insurance company. Premiums are used to pay current-year claims for benefits and claims processing and administrative charges, as well as build reserves to cover certain contingent obligations and unexpected high claims.

Generic Drug: After the patent on a brand drug expires, other pharmaceutical manufacturers may develop, test, and market the same drug. These identical products: generic drugs, contain the exact active ingredients at the same strength and purity as their brand-name counterparts but at a fraction of the price.

Health Maintenance Organization (HMO): A health care financing and delivery system that provides comprehensive healthcare services for enrollees in a particular geographic area. Services must be accessed through the HMO provider network or contracted providers. Employees are encouraged, but not required, to choose a primary care physician (PCP).

High Deductible Health Plan (HDHP): With the exception of preventive care, the annual deductible must be met before plan benefits are paid.

Health Savings Account (HSA): Must be enrolled in HDHP to be enrolled in the HSA.

In-Network (IN): Refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.

Life Event/Special Enrollment: The opportunity to enroll in a group health plan when certain work or life events occur, regardless of the plan's regular enrollment dates. Generally, if certain conditions are met, special enrollment is available when you, your spouse or your dependents lose other coverage (including exhaustion of COBRA continuation coverage), when you marry or when you have a new child by birth, adoption or placement for adoption. The plan must give you at least 30 days from the loss of coverage or from the date of the marriage, birth, adoption or placement for adoption to request special enrollment.

Out-of-Network (OON): Refers to providers or health care facilities that have not contracted with the plan for reimbursement at a negotiated rate. Some health plans, like HMOs, do not reimburse out-of-network providers at all. An out-of–network provider may bill you for the difference between its charge and the allowed amount; this is called balance billing.

Out-of-Pocket Maximum (OOP): The dollar limit of coinsurance amounts that a member is responsible to pay during a calendar year; after a member has reached this limit, the plan will pay most benefits at 100% of the allowed amount for the remainder of the calendar year. Some benefits are not subject to the Maximum Out-of-Pocket provision such as the difference between the allowed amount and the provider's actual charge, any balances due that remain after benefit limits have been reached, and services that are not covered by the plan.

Preferred Provider Organization Plan (PPO): PPOs maintain networks of participating doctors and hospitals who have agreed to charge lower rates for services. When in-network providers are used, the level of benefits is highest and the member avoids having to file claims. A primary care physician (PCP) is not required to coordinate care.

Self-Funded: The employer assumes all liability for claims paid under the health plan. The employer normally contracts for a fee with a TPA to provide claims processing, customer service, and access to provider networks. Advantages to the employer to self-fund include: Optional compliance to state mandated benefits, lower administrative fees, and avoidance of state insurance premium taxes.

SRDP: State Registered Domestic Partner

Step Therapy: The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy medication, only if necessary, to control costs and minimize risks.

Third Party Administrator (TPA): A TPA provides administration services on behalf of a health plan. Services can include: Claims processing, customer service, provider networks, discount arrangements, legal, and plan communications. (i.e., Premera Blue Cross, Kaiser Permanente, Regence, etc.)

Tier: Different levels of payment coverage; drugs in a lower tier will often cost less than drugs in a higher tier [i.e., preferred generic (Tier 1), preferred brand (Tier 2), preferred specialty (Tier 3), non-preferred (Tier 4), etc.].

2027 Monthly Insurance Costs & Contribution

Medical Plans

Plan	Contribution/Cost	Employee Only	Employee + Spouse/SRDP	Employee + Child(ren)	Employee + Family
PPO	Total Cost	$1,273.76	$2,674.90	$2,356.46	$3,757.60
	District Contribution*	$1,273.76	$2,273.66	$2,191.50	$3,381.84
	Employee Cost	**$0.00**	**$401.24**	**$164.96**	**$375.76**
HMO	Total Cost	$1,164.82	$2,446.12	$2,154.92	$3,436.22
	District Contribution*	$1,164.82	$2,348.28	$2,068.72	$3,298.78
	Employee Cost	**$0.00**	**$97.84**	**$86.20**	**$137.44**
HDHP	Total Cost	$1,102.78	$2,315.84	$2,040.14	$3,253.20
	District Contribution*	$1,102.78	$2,200.04	$1,938.14	$3,090.54
	Employee Cost	**$0.00**	**$115.80**	**$102.00**	**$162.66**

Dental Plans

Plan	Contribution/Cost	Employee Only	Employee + Spouse/SRDP	Employee + Child(ren)	Employee + Family
Dental PPO (Delta Dental)	Total Cost	$69.32	$145.58	$128.24	$204.50
	District Contribution*	$69.32	$126.66	$119.26	$184.06
	Employee Cost	**$0.00**	**$18.92**	**$8.98**	**$20.44**
Dental EPO (Willamette)	Total Cost	$69.32	$138.68	$155.32	$225.36
	District Contribution*	$69.32	$133.14	$149.10	$216.34
	Employee Cost	**$0.00**	**$5.54**	**$6.22**	**$9.02**

Vision

Plan	Contribution/Cost	Employee Only	Employee + Spouse/SRDP	Employee + Child(ren)	Employee + Family
EyeMed Vision Care	**Employee Cost**	**$5.84**	**$11.02**	**$11.60**	**$17.00**

Core Term Life Insurance

Plan	Contribution/Cost	Employee Only
1x base salary (excluding OT as of Oct. 15, 2026), rounded to the next $1,000, up to $300,000	District Contribution*	$0.100 per $1,000 coverage
	Employee Cost	**$0.00**

Long-Term Disability (LTD)

Plan	Contribution/Cost	Employee Only
90-day	District Contribution*	$0.204 per $100
	Employee Cost	**$0.00**

From home, go to teampud.com/benefits, you may have to log in with your Microsoft credentials

Core Accidental Death & Dismemberment (AD&D)

Plan	Contribution/Cost	Employee Only
1x base salary (excluding OT as of Oct. 15, 2026), rounded to the next $1,000, up to $300,000	District Contribution*	$0.040 per $1,000 coverage

Voluntary Accidental Death & Dismemberment (AD&D)

This benefit is employee paid.

Coverage	Employee Only	Family Plan
$25,000	**$0.50**	**$1.00**
$50,000	**$1.00**	**$2.00**
$75,000	**$1.50**	**$3.00**
$100,000	**$2.00**	**$4.00**
$150,000	**$3.00**	**$6.00**
$200,000	**$4.00**	**$8.00**
$250,000	**$5.00**	**$10.00**

Voluntary Term Life (VTL)

This benefit is available to employees and spouses, and employee paid. Rates are per person per $1,000 of benefit. Monthly cost for all dependent children: $2/$10,000 coverage.

Age**	Smoker	Non-Smoker
Under 20	**$0.053**	**$0.042**
20 - 24	**$0.053**	**$0.042**
25 - 29	**$0.060**	**$0.045**
30 - 34	**$0.080**	**$0.058**
35 - 39	**$0.108**	**$0.083**
40 - 44	**$0.173**	**$0.100**
45 - 49	**$0.272**	**$0.150**
50 - 54	**$0.424**	**$0.230**
55 - 59	**$0.559**	**$0.422**
60 - 64	**$0.712**	**$0.556**
65 - 69	**$1.270**	**$0.794**
70 - 74	**$2.060**	**$1.503**
75 - 79	**$5.364**	**$2.060**
Over 80	**$5.364**	**$2.060**

***Age as of Jan. 1, 2027*

Part-Time Pay-in-Lieu-of-Benefit Rate

Effective Date	Hourly Rate
Jan. 1, 2027	$7.12

Please note: SRDP and domestic partner costs for non-tax dependents are paid after tax

**Regular full-time employees and eligible part-time employees (enrolled in medical and dental) receive District Contribution*

Supplemental Voluntary Benefits

These benefits are all employee paid.

Benefit	Employee Only	Employee + Spouse/SRDP	Employee + Child(ren)	Employee + Family
Hospital Indemnity	$19.04	$43.84	$29.02	$56.14
Accident Insurance	$7.16	$11.68	$16.00	$22.90

Critical Illness

Coverage Level	Age**	Employee Only	Employee + Spouse/SRDP	Employee + Child(ren)	Employee + Family
$10,000	Under 30	$ 2.56	$ 5.12	$ 5.08	$ 8.22
	30-34	$ 3.56	$ 7.28	$ 6.08	$ 10.40
	35-39	$ 4.68	$ 9.68	$ 7.20	$ 12.80
	40-44	$ 6.36	$ 13.04	$ 8.90	$ 16.14
	45-49	$ 9.28	$ 18.52	$ 11.80	$ 21.64
	50-54	$ 14.02	$ 27.32	$ 16.54	$ 30.44
	55-59	$ 19.80	$ 38.00	$ 22.32	$ 41.12
	60-64	$ 28.32	$ 53.82	$ 30.86	$ 56.94
	65-69	$ 38.02	$ 71.96	$ 40.54	$ 75.06
	70 & Over	$ 55.40	$ 104.76	$ 57.92	$ 107.88
$20,000	Under 30	$ 4.06	$ 8.06	$ 7.80	$ 12.66
	30-34	$ 5.92	$ 12.08	$ 9.64	$ 16.68
	35-39	$ 8.00	$ 16.48	$ 11.74	$ 21.10
	40-44	$ 11.48	$ 23.40	$ 15.22	$ 28.00
	45-49	$ 17.46	$ 34.80	$ 21.20	$ 39.42
	50-54	$ 26.98	$ 52.54	$ 30.72	$ 57.14
	55-59	$ 38.56	$ 73.92	$ 42.28	$ 78.52
	60-64	$ 55.62	$ 105.56	$ 59.34	$ 110.16
	65-69	$ 74.98	$ 141.82	$ 78.72	$ 146.42
	70 & Over	$ 109.76	$ 207.44	$ 113.48	$ 212.06
$30,000	Under 30	$ 5.56	$ 11.02	$ 10.50	$ 17.10
	30-34	$ 8.28	$ 16.88	$ 13.22	$ 22.98
	35-39	$ 11.34	$ 23.30	$ 16.28	$ 29.40
	40-44	$ 16.58	$ 33.76	$ 21.54	$ 39.86
	45-49	$ 25.64	$ 51.08	$ 30.58	$ 57.18
	50-54	$ 39.94	$ 77.76	$ 44.90	$ 83.86
	55-59	$ 57.32	$ 109.82	$ 62.26	$ 115.92
	60-64	$ 82.90	$ 157.30	$ 87.84	$ 163.40
	65-69	$ 111.94	$ 211.70	$ 116.90	$ 217.78
	70 & Over	$ 164.10	$ 310.12	$ 169.06	$ 316.22
$40,000	Under 30	$ 7.04	$ 13.94	$ 13.18	$ 21.54
	30-34	$ 10.64	$ 21.68	$ 16.78	$ 29.26
	35-39	$ 14.66	$ 30.08	$ 20.82	$ 37.66
	40-44	$ 21.68	$ 44.10	$ 27.82	$ 51.68
	45-49	$ 33.78	$ 67.30	$ 39.94	$ 74.88
	50-54	$ 52.86	$ 102.90	$ 59.02	$ 110.48
	55-59	$ 76.00	$ 145.60	$ 82.14	$ 153.20
	60-64	$ 110.08	$ 208.84	$ 116.24	$ 216.44
	65-69	$ 148.78	$ 281.30	$ 154.92	$ 288.88
	70 & Over	$ 218.26	$ 412.42	$ 224.40	$ 420.02

From home, go to teampud.com/benefits, you may have to log in with your Microsoft credentials

Vendor Contacts

PPO & HDHP Plans, Group #1039248

Premera Blue Cross (claims administrator) 1-800-722-1471
- 24-hour NurseLine 1-800-841-8343
- Website ..... www.premera.com
- Network (Washington & Alaska) ..... Heritage & Heritage Plus 1
- Network (USA, outside Washington & Alaska) ..... BlueCard PPO (Prefix=SQN)
- Network (out of the country) ..... BlueCard Worldwide Program 1-800-810-BLUE (2583)

Virtual care:
- Transcarent ..... www.premera.com/visitor/virtual-care
- Spring Health and Talkspace ..... www.premera.com (secure member portal) or Premera mobile app

PPO Plan Pharmacy:
- Drug List="E4" ..... www.premera.com/visitor/covered-drugs

Express Scripts (pharmacy benefit administrator) 1-800-391-9701
- Website ..... www.premera.com/pharmacy
- Mail Order ..... www.premera.com/mypharmacyplus

Specialty RX Pharmacy – Accredo 1-800-689-6592
Blue365 (discounted programs for health/wellness products) blue365deals.com/Premera

HMO Plan, Group #0061600

Kaiser Permanente (claims administrator) 1-888-901-4636
24-hour Consulting Nurse 1-800-297-6877
Website ..... www.kp.org/wa
Network ..... Core
Pharmacy Mail Order 1-800-245-7979

DPPO, Group #0602

Delta Dental of Washington 1-800-554-1907
Website ..... www.deltadentalwa.com
Networks ..... Dental Dental PPO and Delta Dental Premier

DEPO, Group #WA156

Willamette Dental Group 1-855-433-6825
Website ..... willamettedental.com
Snohomish County PUD custom microsite: ..... willamettedental.com/snohomish_county_pud/

Vision Plan, Group #1040734

EyeMed Vision Care 1-866-939-3633
Website ..... www.eyemed.com/en-us
Online options ..... www.glasses.com | www.contactsdirect.com | www.lenscrafters.com | www.targetoptical.com | www.ray-ban.com/usa
Find an eye doctor ..... eyedoclocator.eyemedvisioncare.com
Lasik 1-877-552-7376
Network ..... Access

Flexible Spending Accounts & Health Savings Account (Pre-Tax Benefits Unit)

ThrivePass ..... 1-866-855-2844 | Press 1 (Pre-tax), 7:30 am - 5:30 pm M-Th; 7:30 am - 5:00 Fri (CT)
Website ..... www.thrivepass.com
Email ..... tpa@thrivepass.com

Life, Disability, VTL/AD&D ID #174445

The Standard Insurance Company 1-888-937-4783
Website ..... www.standard.com

Critical Illness ID#76465, Accident Insurance ID #76464, Hospital Indemnity ID# 76466

Securian Life Insurance Company 1-855-750-1906
Website ..... securian.com/pud-insurance

Additional Resources

Go to Benefit Central to make changes to your benefits

From a District device (logged into District network):

Click on the Employee Central icon on your District desktop, then click on Benefit Central tile.

From an external device:

Go to snopud.com and click on the "PUD Employees/Retirees" link at the bottom of the page, then click on Active Employees link for Employee Central login & then click on Benefit Central tile.



Benefit Information

To access Benefits information go to teampud.com/benefits.

Human Resources Benefits Team

Questions on specific benefits? Contact the Human Resources Benefits Team:

Phone 425-783-8557
Email . . . . . hrbenefits@snopud.com
Fax 425-783-8675

Retirement

Department of Retirement Systems (DRS)

Phone 1-800-547-6657
Website . . . . . www.drs.wa.gov

MissionSquare (401K/457/RHS plans)

Plan Numbers: 401K = 106638; 457 = 306931; RHS = 803083

Phone 1-800-669-7400
Website . . . . . www.missionsquare.com
Sonia Rogers, Retirement Plans Specialist . . . . . 202-759-7143 / sorogers@missionsquare.com
Keith Penewit, Certified Financial Planner . . . . . 202-759-7015 / kpenewit@missionsquare.com

Life / Long-Term Care

The Standard (American Heritage Life Insurance Company)

Phone . . . . . 1-800-521-3535 Ext 3 ("Life")
Website . . . . . standard.com/ahl/mybenefits

Employee Assistance Program

SupportLinc EAP

Phone 1-800-553-7798
Website . . . . . supportlinc.com
On first visit enter code: snohomishcountypud (no spaces, not case sensitive) to create an account

You are not alone. Mental health matters.

In the U.S., 1 in 3 adults report symptoms of depression or anxiety.

If you or someone in your family would like help, there are many resources available at the District.

Scan the QR code or visit teampud.com/mentalhealth.

If you or someone you know is in crisis, call or text 988. Learn more at 988lifeline.org.