2026

EMPLOYEE FEHB BENEFITS GUIDE

Plan Year:
1/1/26 to 12/31/26

THE MAHONEY GROUP®

Walker River Paiute Tribe

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WALKER RIVER PAIUTE TRIBE BENEFITS

At **Walker River Paiute Tribe,** we know our dedicated employees—YOU—are key to our overall success as an organization. We recognize that offering a quality, comprehensive benefit program is an important way to show you how valuable you are to the organization. We understand that navigating the world of employee benefits is challenging and no two employees are alike, which is why we offer this benefits guide to explain the multiple benefit options to improve your physical, financial and mental well-being.

This booklet provides a summary of plan highlights. Please consult the carrier contract for complete information on covered changes, limitations, and exclusions. This is not a binding contract. In the event of any discrepancy, the carrier's contract will prevail. If you have further questions, please contact the insurance carrier or Human Resources.

ELIGIBILITY

If you are a full-time employee (working 30+ hours a week), you are eligible to enroll in our medical, dental and vision benefits and you will be automatically enrolled in our Life and Accidental Death and Dismemberment (AD&D) plan. As a new hire, benefits are effective on the first of the month following 60 days of consecutive employment. You must enroll by the date before your benefits effective date. If you do not meet this deadline, you will need to wait until the next open enrollment period to enroll.

COVERING YOUR FAMILY MEMBERS

Many of the plans offer coverage for your eligible family members, including:

- Your legal spouse
- Your dependent children, including your stepchildren, legally adopted children, children placed with you for adoption or for court ordered legal guardianship
- Dependent children are eligible for medical, dental, and vision up to the end of the month in which they turn age 26 (regardless of student or marital status)
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

CHANGING YOUR BENEFITS DURING THE YEAR

Most benefit deductions are withheld from your paycheck on a pre-tax basis (i.e. medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change (sometimes called a "Qualifying Event" or "Life Event").

The most common qualifying life events are:

- Marriage, legal separation or divorce
- Birth, adoption or change in legal custody of eligible child(ren)
- Change in you or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's open enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order

To make benefit changes as a result of a Qualifying Event as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within **30 days** of the date of the qualifying event
- Provide proof of your life status event

COVERAGE STARTS

- If you enroll during open enrollment, your coverage is effective **January 1st , 2026.**
- As a new hire, coverage is effective **first of the month following 60 days of consecutive employment.**

QUALIFYING EVENT EFFECTIVE DATES

- Coverage changes from a qualifying event will be effective **first of the month following the event date** unless in the case of a new child, your change in coverage will be effective on the **date of birth or adoption.**

COVERAGE ENDS

- If your employment with **Walker River Paiute Tribe** terminates (voluntarily or otherwise), **your benefits will end at the end of the month** (aside from life insurance benefits, which end on the date of your termination).

BENEFITS ENROLLMENT

Open enrollment is the only time during the year that you can change your benefits without experiencing a qualifying life event. During the open enrollment period, you have the opportunity to newly enroll in coverage and/or make changes to your current coverage, including adding or removing dependents. Any changes you make for open enrollment become effective January 1st .

ENROLLMENT

Benefits enrollment is completed online through the **Employee Navigator** website at **www.employeenavigator.com**.

In order to complete your enrollment, you need:

- Dates of birth and social security numbers for yourself as well as any family members you are enrolling.
- **Proof of eligibility for your spouse and dependent children (e.g., marriage license, birth certificate).**

NEED TO KNOW UPDATES AND INFO

- What is new/changing for **2026**
- Consider what is new with you… did you have a baby, get married, etc. that may affect your enrollment decisions
- Open Enrollment dates: **December 1st – December 5th**
- **What you need to do to make changes/newly enroll**

MEDICAL INSURANCE

Employees

Coverage is provided by the Federal Employees Health Benefits (FEHB) Program for medical and prescription drug coverage. Here are some details on the FEHB Program, eligibility, enrollment, plan information, premium rates, and more.
The Patient Protection and Affordable Care Act, Public Law 111-148, incorporated and enacted S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, resulting in the addition of section 409 to the IHCIA (codified at 25 U.S.C. 1647b). Under IHCIA section 409, an Indian tribe or tribal organization carrying out programs under the Indian Self Determination and Education Assistance Act (ISDEAA), or an urban Indian organization carrying out programs under title V of IHCIA, is entitled to purchase coverage, rights, and benefits under the Federal Employees Health Benefits (FEHB) Program for their employees.
The Consolidated Appropriations Act of 2021, Public Law 116-260, amended section 409 of the IHCIA (25 U.S.C. 1647b). Under 25 U.S.C. 1647b, an Indian tribe or tribal organization carrying out programs under the Tribally Controlled Schools Act (TCSA (25 U.S.C. 2501 et seq.) is entitled to purchase coverage, rights, and benefits under the FEHB Program for their employees.
Rates and contributions are automatically calculated in Employee Navigator for each plan. Please log into the system to view the plans and rates.

- **Note:** the term tribal employers is used to designate tribes, tribal employers, urban Indian organizations and tribal grant schools

Where to go for more Information

Visit the websites at https://www.opm.gov/healthcare-insurance/insurance-faqs/ to learn more about the FEHB Program.
If you have specific questions, please contact The Mahoney Group.

What you should consider when choosing a plan

◈What benefits does the plan cover? What are your expected healthcare needs for you and your family? Do you need certain medications? Make sure the plan covers the services or supplies that are important to you and know its limitations an exclusions.

◈What are my out-of-pocket costs? Does the plan have a deductible to meet (the amount you first pay before the plan pays benefits)? What is the copay of coinsurance?

◈Are my doctors, hospitals and other care providers in the plan's network? Your costs are lower with in-network providers.

◈How well does my plan provide quality care? Quality care varies with plans. Please use the three sources below for reviewing quality:

1. Member survey results - evaluations by current plan members are posted in the Health Plan Comparison Tool.

   Enter your zip code at www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/

   Zip code: 89427 Enrollment type: Tribal Employee
   Summary of Benefits and Coverage:
   Select Plans, select Compare at bottom of page, select Summary of Benefits link

2. Effectiveness of care - how a plan performs in preventing or treating common conditions found at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/quality

3. Accreditation - evaluations of health plans by independent accrediting organizations. Go to http://reportcard.ncqa.org/plan/external/plansearch.aspx

4. Prescription Search - https://www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/ Put in zip code and select the "Tribal" radio button. Select "Search" at the bottom of the page. When you select a plan, then select "compare plans" at the bottom of the page. Click on RX Pricing Tool link at the top of the plan. And type in information under "Prescription Search. It shows the pharmacies that carry it. Select "View Prices" to the right and the prices are shown for each plan.

BCBS will have the largest Nationwide Network of providers, so please start by reviewing those plans, but feel free to select any plan that is available to you based on your zip code.

MEDICAL INSURANCE

What types of plans does the FEHB Program offer?

Eligible employees can choose from a number of health insurance plans. The following chart compares the types of plans available to help you select the one that is best for you.

	Choice of doctors, hospitals, pharmacies and other providers	Specialty Care	Out-of-pocket costs	Paperwork
Fee-for-Service w/PPO (Preferred Provider Organization)	You must use the plan's network to reduce your out-of-pocket costs. For BCBS Basic Option, you must use preferred providers for your care to be eligible for benefits.	Referral not required to receive benefits.	You pay fewer costs if you use a PPO provider than if you don't.	Some, if you don't use network providers.
Health Maintenance Organization	You generally must use the plan's network to reduce your out-of-pocket costs.	Referral generally required from primary care doctors to receive benefits.	Your out-of-pocket costs are generally limited to copayments.	Little, if any.
Point-of-Service	You must use the plan's network to reduce your out-of-pocket costs. You may go outside the network but you will pay more.	Referral generally required to receive maximum benefits.	You pay less if you use a network provider than if you don't.	Little, if you use the network. You have to file your own claims if you don't use the network.
Consumer-Driven Plans w/Health Reimbursement Arrangement (HRA)	You may use network and non-network providers. You will pay more by not using the network.	Referral not required to receive maximum benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	Some, if you don't use network providers. You may need to file a claim for reimbursement from your HRA.
High Deductible Health w/Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)	Some plans are network only; others pay something even if you do not use a network provider.	Referral not required to receive maximum benefits from PPO.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	Some, if you don't use network providers. You may need to file a claim for reimbursement from your HSA or HRA.

MEDICAL BENCHMARK PLAN

Plan networks will vary, some offer a national network while others are state-specific HMO plans.

Below is the **benchmark** BlueCross BlueShield Basic medical plan which offers in-network benefits only. For the BCBS Basic benchmark plan, you have the flexibility to select any provider in-network without a referral.

This table summarizes the key features of the **benchmark** BCBS medical plan which represents the base plan option. The coinsurance amount listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

	In-Network Only
Medicare Part D Creditable Coverage	Yes
Deductible (individual/family)	$0
Out-of-pocket maximum (individual/family)	$ 7,500 / Self Only $ 15,000 / Self Plus One $ 15,000 / Self and Family
Preventive care	No charge
Office visits (primary care/ specialist)	$35 / $50
Emergency Room	$425 per day per facility
Urgent Care	$50
Lab/x-ray	20% for blood work; $40 for X-rays
Inpatient hospital	$425 per day up to maximum of $2,975 per admission
Outpatient hospital	$250 per day per facility
Therapies	50 visit limit per calendar year
Rx (generic/preferred/brand/specialty)	$15 / $35 ($150 max) / 60% / 35% ($250 max) (Preferred), 35% ($500 max)(Non-preferred)

BCBS TELEHEALTH AND 24/7 NURSELINE

$0 telehealth visits when you need them

With telehealth services, you can connect with a doctor anytime by phone, video chat, or the Teladoc Health app—for free.

Your telehealth benefit includes:

- 24/7 General Medical Care
- Mental Health Consults
- Dermatology Services
- Nutritional Counseling
- Global Care *(For overseas members)*

Learn more or register for Teladoc Health today at **fepblue.org/telehealth** or call **1-855-636-1579**.

If your in-network doctors offer phone or video visits, we'll cover them. You'll pay the same cost share as an in-person visit.

Our 24/7 Nurse Line is ready to help

Whether you have a health question or need help deciding where to go for healthcare services, you can get expert care advice from qualified registered nurses—anytime, at no extra cost to you. Members can call 1-888-258-3432 to reach one of our nurses.

BCBS MEMBER PORTAL

Helpful tools on MyBlue® to help you get the most out of your benefits

Through a variety of online tools and resources, we can help you stay informed, manage your costs and more once you're a member. Learn more at **fepblue.org/myblue**.

Know your health care costs

See how close you are to meeting your annual deductible or visit limits as well as what you've paid in claims this year.

Manage your coverage

Most members don't know they can go paperless. In MyBlue, go electronic with your Explanation of Benefits (EOB), use the FEP Prescription Drug Cost Tool, and easily view your claims, prescriptions and medical records, all in one secure place.

Get estimates for anticipated care and services

You can search for certain treatments and get estimates for how much they'll cost.

Questions about FEP?

We're here to help. Visit **fepblue.org** to explore benefits or manage your account if you're already an FEP member.

Prefer to talk to someone? Call **1-800-411-BLUE (2583)** or the number on the back of your member ID card.

Download the fepblue app to do more on the go

Download the **fepblue app** for easy access to your health insurance benefits—view your digital member ID card, find in-network providers, connect to virtual care, and get updates on the go.

Download on the App Store

GET IT ON Google Play

HEALTH AND WELLNESS PROGRAMS

Get rewarded for completing activities that support your health

Earn $50 for taking the Blue Health Assessment

With the Blue Health Assessment (BHA), you can get a snapshot of your health and get rewarded. This simple quiz takes between 10-12 minutes to complete and you'll get instant feedback on ways you can improve or maintain your health. **FEP Blue Basic** and **FEP Blue Standard** members can earn $50 the first time they take the BHA in 2026.

You must be the contract holder or spouse, 18 or older, on a FEP Blue Standard or FEP Blue Basic plan to earn incentive rewards.

Earn $120 for completing Daily Habits

Daily Habits helps you set and reach your health goals. Whether you want to eat better, stress less or get help managing a chronic condition, Daily Habits can help. **FEP Blue Basic** and **FEP Blue Standard** members can earn $120 for completing three eligible goals in 2026.

You must be the contract holder or spouse, 18 or older, on a FEP Blue Standard or FEP Blue Basic plan to earn incentive rewards.

You can complete activities related to:

You must be the contract holder or spouse, 18 or older, on a FEP Blue Standard or FEP Blue Basic plan to earn incentive rewards.

Earn $75 plus more with our Pregnancy Care Incentive Program

Pregnant **FEP Blue Basic** and **FEP Blue Standard** members can earn a $75 reward and receive a free Pregnancy Care Box when they complete a prenatal checkup in their first trimester.

Get a $150 reward for completing your annual physical

With the Routine Annual Physical Incentive Program, **FEP Blue Focus** members can earn a $150 MyBlue® Wellness Card just for getting their annual checkup. It's a simple way to stay on top of your health. Your doctor can help identify health risks early and offer tips to manage them.

Location restrictions apply. You must be 18 or older and the contract holder or spouse on an FEP Blue Focus plan to earn this reward. We encourage you to consider possible tax implications of your rewards as part of this program and to consult your tax, legal or accounting advisors for additional information. Not all BlueSM vendors are included in this program.

Earn rewards for taking charge of your health at fepblue.org/incentives.

DENTAL INSURANCE

Mutual of Omaha: Dental PPO (DPPO).

The PPO dental plan includes in- and out-of-network benefits, which means you can choose any dentist that you would like. However, you will pay less out of your pocket when you choose an In-network dentist. Locate an In-network dentist at **www.mutualofomaha.com**.

The table below summarizes the key features of the dental plan. The coinsurance amounts listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

DO I NEED TO SEE A DENTIST?

A visit to the dentist is about more than just a teeth cleaning. By looking in your mouth, your dentist can tell a lot about your overall health. In fact, he or she may be able to identify early signs of disease, such as diabetes, heart disease, kidney disease, and even some forms of cancer, before you even notice symptoms.

	In-network	Out-of-network
Deductible (individual/family)	$50 / $150	$100 / $300
Annual Benefit Maximum	$1,500	
Orthodontics Lifetime Maximum	$1,500 – Child only	
Diagnostic/preventive Services	0%	20%
Basic Services	20%	50%
Major Services	50%	50%
Orthodontics Services	50%	50%

VISION INSURANCE

We offer a vision insurance plan through **Mutual of Omaha**. This plan allows you to choose any eye care provider. However, you will maximize the plan benefits when you choose a in-network provider. Locate an in-network provider at **www.mutualofomaha.com/vision**.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	In-network	Out-of-network
Frequency of Glasses/Lenses/Frames	12 / 12 / 24	
Exams Retinal Imaging	$10 copay Up to $39	Up to $37 Not Applicable
Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive	 $25 copay $25 copay $25 copay $25 copay $65 copay	 Up to $20 Up to $36 Up to $64 Up to $64 Up to $36
Frames	$130 allowance + 20% off balance	Up to $58
Contacts Standard Contact Lens Fit & Follow-up Premium Contact Lens Fit & Follow-up	$130 allowance + 15% off balance Up to $40 10% off retail price	Up to $89 Not Applicable Not Applicable
Laser Correction	15% off retail price or 5% off promotional price	

DO I NEED AN ANNUAL EYE EXAM IF I HAVE PERFECT VISION?

Your eyes are your windows to the world. They are also your eye doctor's windows into your body. Just by looking in your eyes, a doctor can find warning signs of serious diseases and conditions like high blood pressure, high cholesterol, thyroid diseases, and certain types of cancer. In fact, eye doctors are frequently the first to detect signs of abnormal health conditions.

BASIC LIFE AND AD&D INSURANCE

Life and accidental death and dismemberment (AD&D) insurance provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, your beneficiary will receive both the life and AD&D benefits.

We provide you with basic life and AD&D insurance at **no cost to you.**

If you are eligible for **$50,000** or more in life insurance, you are required to pay income tax on the value of the coverage in excess of **$50,000.**

DESIGNATE A BENEFICIARY

In the event of your death, your beneficiary would receive your Life and/or AD&D proceeds. Designate your beneficiary for your Basic Life and AD&D insurance. You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

BENEFIT HIGHLIGHTS	
Employee Life Benefit Amount	$50,000
Guarantee Issue Amount	$50,000
Employee AD&D Benefit Amount	Same as Life
PLAN PROVISIONS	
Age Reduction Schedule	• 65% of benefit at age 70 • 50% of benefit at age 75
Basic Life Accelerated Death Benefit	If you become terminally ill while you are insured by Mutual of Omaha will pay you a portion of your life insurance benefit one time. You may elect 75% of the amount of the life insurance benefit, not to exceed $37,500
Waiver of Premium	If you become and remain totally disabled for more than 9 months, your life insurance coverage may be continued for a specific time and your life insurance premium will be waived (subject to approval from Mutual of Omaha).

SUPPLEMENTAL LIFE/AD&D

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. You have the option to purchase voluntary life and AD&D insurance at group rates through Mutual of Omaha. You may also purchase voluntary coverage for your spouse and eligible children.

Benefit Option		Guaranteed Issue
Employee	$10,000 increments up to $500,000, no more than 5 times annual salary	$100,000
Spouse/DP	100% of employee's benefit up to $100,000	$25,000
Child(ren) Under age 26	100% of employee's benefit up to $10,000	$10,000

EVIDENCE OF INSURABILITY

If you purchase Life and AD&D insurance for yourself or your spouse and/or children when you are first eligible to enroll, you may purchase up to the guarantee issue amounts without completing a statement of health (evidence of insurability). If you do not enroll when first eligible and choose to enroll during a future open enrollment period, you will be required to submit evidence of insurability for any amount of coverage. Coverage will not take effect until approved by Mutual of Omaha.

BENEFICIARY DESIGNATION

In the event of a death, the Beneficiary would receive the Life and/or AD&D proceeds. Don't forget to designate the beneficiaries for your coverage, your spouse's coverage and/or child coverage.

You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

SUPPLEMENTAL VOLUNTARY BENEFITS

Walker River Paiute Tribe provides you the option to purchase **accident insurance and critical illness insurance** through **Mutual of Omaha.** The amount you pay for two plans is deducted from your paycheck on a post-tax basis. This ensures that any payments you receive are not taxed. Learn more about the accident and critical illness plans at **www.mutualofomaha.com.**

ACCIDENT INSURANCE

Accident insurance is a policy that can help you pay expenses that may follow an accident, including out-of-pocket health care costs. This plan pays benefits if you are injured in an accident, regardless of whether or not you are at work.

KEY FEATURES OF THE ACCIDENT INSURANCE PLAN:

- You are paid cash quickly
- The amount you receive is based on your injuries, services provided, and treatment
- You can use the money for whatever you would like
- Benefits are not taxed
- It does not matter what medical plan you have

	ACCIDENT INSURANCE RATE
Employee Only	$6.02
Employee + Spouse	$8.71
Employee + Child(ren)	$10.69
Employee + Family	$14.07

KEY FEATURES OF THE CRITICAL ILLNESS INSURANCE PLAN:

YOU MUST ENROLL EACH YEAR TO PARTICIPATE.

- You are paid cash quickly
- You can use the money for whatever you would like
- It does not matter what medical plan you have

Health screening benefit: Pays a flat, annual benefit of $100 for a health screening test.

CRITICAL ILLNESS INSURANCE

Critical illness insurance is a policy that provides a lump-sum, cash benefit if you are diagnosed with a covered illness (e.g., heart attack, stroke, cancer). These diagnoses can cause significant financial burden, especially if you are unable to work while receiving treatment. You can use the money you receive however you would like, including to help you pay your mortgage, pay your deductible, seek experimental treatment, or for any other expenses. The benefit amount you receive is based on the level of coverage you purchase. You may also purchase coverage for your spouse and/or dependent children.

Coverage Options:

- Employee: **In increments of $5,000 up to $20,000; guarantee issue: $20,000.**
- **Spouse: In increments of $5,000 up to $20,000, 100% of employee's CI Principal Sum; guarantee issue: $20,000.**
- Dependent children to age **26: 25% of employee's CI Principal Sum up to $5,000; guarantee issue: $5,000.**

MEDICAL, DENTAL, AND VISION PREMIUM RATES

BENCHMARK BCBS BASIC MEDICAL COST PER PAY PERIOD (24)

	Benchmark BCBS BASIC	
Employee Only	$0.00	Alternative plan premiums available on Employee Navigator
Employee + One	$619.55	
Employee + Family	$732.73	

DENTAL/VISION COST PER PAY PERIOD (24)

	DENTAL	VISION
Employee Only	$18.47	$3.13
Employee + Spouse	$36.32	$7.18
Employee + Child(ren)	$48.39	$7.96
Employee + Family	$71.79	$12.15

Walker River Paiute Tribe sponsors a Section 125 Premium Only Plan. This means your premiums will be deducted on a before-tax basis, saving you payroll taxes which slightly increases your take-home pay. If you wish to pay your premiums on an after-tax basis, please ask HR for a waiver form.

VOLUNTARY LIFE AND CRITICAL ILLNESS INSURANCE PREMIUM RATES

VOLUNTARY LIFE AND AD&D COST (24 PAY PERIODS)

EMPLOYEE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
30 - 34	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
35 - 39	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40 - 44	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
45 - 49	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00
50 - 54	$2.05	$4.10	$6.15	$8.20	$10.25	$12.30	$14.35	$16.40	$18.45	$20.50
55 - 59	$3.10	$6.20	$9.30	$12.40	$15.50	$18.60	$21.70	$24.80	$27.90	$31.00
60 - 64	$4.60	$9.20	$13.80	$18.40	$23.00	$27.60	$32.20	$36.80	$41.40	$46.00
65 - 69	$7.70	$15.40	$23.10	$30.80	$38.50	$46.20	$53.90	$61.60	$69.30	$77.00
70+	$12.45	$24.90	$37.35	$49.80	$62.25	$74.70	$87.15	$99.60	$112.05	$124.50

SPOUSE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.23	$0.45	$0.68	$0.90	$1.13	$1.35	$1.58	$1.80	$2.03	$2.25
30 - 34	$0.28	$0.55	$0.83	$1.10	$1.38	$1.65	$1.93	$2.20	$2.48	$2.75
35 - 39	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
40 - 44	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
45 - 49	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
50 - 54	$1.03	$2.05	$3.08	$4.10	$5.13	$6.15	$7.18	$8.20	$9.23	$10.25
55 - 59	$1.55	$3.10	$4.65	$6.20	$7.75	$9.30	$10.85	$12.40	$13.95	$15.50
60 - 64	$2.30	$4.60	$6.90	$9.20	$11.50	$13.80	$16.10	$18.40	$20.70	$23.00
65 - 69	$3.85	$7.70	$11.55	$15.40	$19.25	$23.10	$26.95	$30.80	$34.65	$38.50

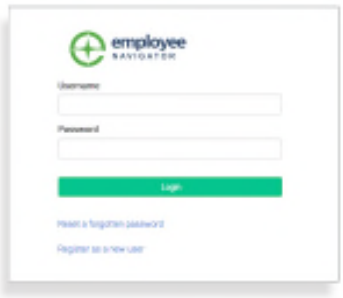
ALL CHILDREN PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)*								
$2,000	**$3,000**	**$4,000**	**$5,000**	**$6,000**	**$7,000**	**$8,000**	**$9,000**	**$10,000**
$0.29	$0.44	$0.58	$0.73	$0.87	$1.02	$1.16	$1.31	$1.45

CRITICAL ILLNESS INSURANCE COST (24 PAY PERIODS)

VOLUNTARY CRITICAL ILLNESS EMPLOYEE PREMIUM RATES (24 PAYROLL DEDUCTIONS PER YEAR)				
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**
0 - 29	$0.98	$1.95	$2.93	$3.90
30 - 39	$1.70	$3.40	$5.10	$6.80
40 - 49	$3.48	$6.95	$10.43	$13.90
50 - 59	$6.88	$13.75	$20.63	$27.50
60 - 69	$13.90	$27.80	$41.70	$55.60
70 - 79	$25.83	$51.65	$77.48	$103.30
80+	$36.23	$72.45	$108.68	$144.90

EMPLOYEE NAVIGATOR

ENROLL IN YOUR BENEFITS: One step at a time

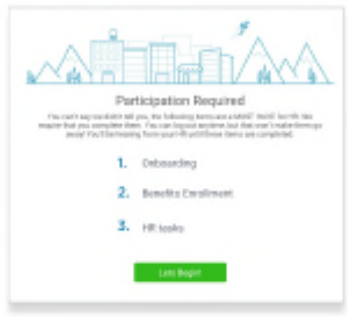


Step 1: Log In

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

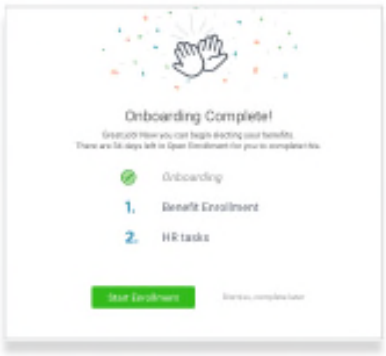
- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.

Company Identifier:
WalkerRiver



Step 2: Welcome!

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

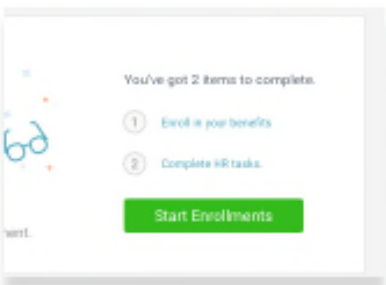


Step 3: Onboarding (For first time users, if applicable)

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

TIP

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



Step 4: Start Enrollments

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

TIP

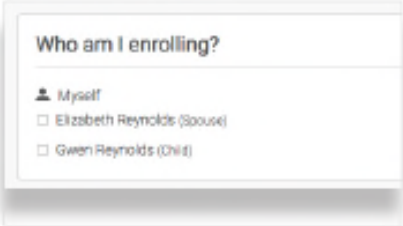
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

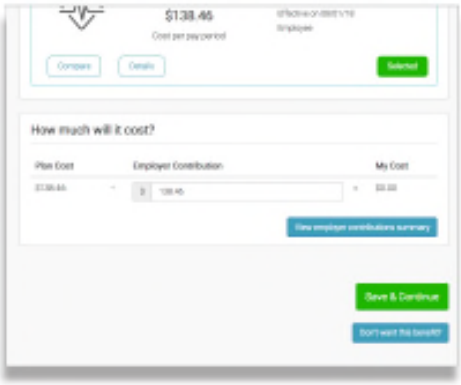
EMPLOYEE NAVIGATOR

Step 5: Benefit Elections

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

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





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

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

Step 6: Forms

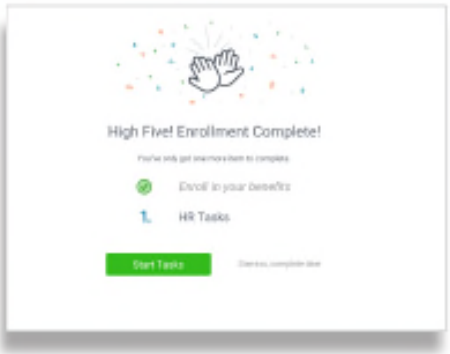
If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

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

TIP

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



Step 8: HR Tasks (if applicable)

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

You can login to review your benefits 24/7

RESOURCES AND CONTACT INFO

- **BENEFITS WEBSITE: https://www.wrpt.org/**
- **FAQS: djohnson@mahoneygroup.com**
- **ENROLLMENT PORTAL: www.employeenavigator.com**

BENEFIT	PHONE	WEBSITE / EMAIL
Medical - FEHB	Contact member services on the back of your ID card	Contact member services on the back of your ID card
BCBS Basic Benchmark Telemedicine	1-855-636-1579	fepblue.org/telehealth
Telemedicine for other carriers	Contact member services on the back of your ID card	Contact member services on the back of your ID card
Dental	800-775-6000	www.mutualofomaha.com
Vision	800-775-6000	www.mutualofomaha.com/vision
Voluntary benefits	800-775-6000	www.mutualofomaha.com
Life and AD&D	800-775-6000	www.mutualofomaha.com
Human Resources Shalone Alvarado	775-773-2306	hrdirector@wrpt.org
The Mahoney Group Denise Johnson, Account Manager	480-214-2797	djohnson@mahoneygroup.com

ANNUAL NOTICES

Each year, employers that offer health care benefit plans are required to provide specific state and federal notices to employees regardless of their participation in the benefit plans offered. The following pages are summaries of the Annual Notices. If you have any questions, please contact the **Benefits Department at 775-773-2306.**

SUMMARY ANNUAL NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

If you're eligible for Medicaid or CHIP and have employer-sponsored health coverage, your state may offer premium assistance to help with premiums.

Steps to take:

1. **Already Enrolled**: Contact your state Medicaid/CHIP office to inquire about premium assistance.
2. **Not Enrolled**: Visit insurekidsnow.gov or contact your state Medicaid/CHIP office to apply and check eligibility.
3. **Special Enrollment**: If you qualify for Medicaid or CHIP premium assistance, your employer must allow you to enroll in their health plan within 60 days of approval.
4. **For Questions**: The U.S. Department of Labor can be reached at 1-866-444-EBSA (3272), or visit askebsa.dol.gov.

Note: Medicaid and CHIP premium assistance programs vary by state. For more specific details, please contact your state's Medicaid or CHIP office.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

FMLA provides eligible employees with up to 12 weeks of unpaid, job-protected leave per year for certain personal or family reasons.

Key Details:

- **Eligibility**: Employees must have worked for 12 months, 1,250 hours in the last 12 months, and be employed at a worksite with 50+ employees.
- **Leave Reasons**: Birth or adoption of a child, caring for a family member with a serious health condition, or the employee's own serious health condition.
- **Intermittent Leave**: Employees can take leave intermittently if medically necessary.
- **Job Protection**: Employees must be reinstated to the same or equivalent position after their leave.
- **Health Insurance**: Employers must continue health insurance during FMLA leave.
- **FMLA Request**: Employees must give 30 days' notice, or as much notice as possible if leave is unexpected.

For FMLA-related complaints, contact the **U.S. Department of Labor Wage and Hour Division** at 1-866-487-9243 (TTY: 1-877-889-5627) or visit www.dol.gov/whd.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

GINA prohibits discrimination based on genetic information.

Key Points:

- Employers cannot request or require genetic information, except in limited circumstances.
- Genetic information includes family medical history, genetic test results, and information about genetic services.
- Employees should avoid providing genetic information unless required by law.

For more information, visit the EEOC's GINA page.

SUMMARY ANNUAL NOTICES

HEALTH INSURANCE MARKETPLACE NOTICE

Even if your employer offers health insurance, you may have other options through the Health Insurance Marketplace. This notice explains how Marketplace coverage interacts with your employer-provided plan.

What is the Marketplace?
The Marketplace is a resource where you can compare and purchase private health insurance. It's designed to help you find coverage that fits your needs and budget.

Can You Save Money in the Marketplace?
You may qualify for savings (like premium tax credits) if:

- Your employer does not offer coverage, or
- The coverage is not affordable (costs more than **9.96% of your income for 2026)**, or
- It does not meet minimum value standards set by the ACA.

If your employer offers affordable, minimum value coverage, you likely won't be eligible for Marketplace savings.

Enrollment Periods:

- Open Enrollment runs each year (generally November 1 – December 15).
- You may qualify for a Special Enrollment Period if you experience a life event (e.g., marriage, birth, loss of coverage).
- A temporary Special Enrollment Period is available if you lose Medicaid or CHIP coverage generally run between March 31 – July 31.

Other Coverage Options:
You may be eligible to:

- Enroll in your employer's plan after losing Medicaid/CHIP.
- Apply for Medicaid or CHIP at any time at HealthCare.gov.

Employer Coverage Overview
Your employer offers:

- Health insurance to all eligible employees
- **Coverage for spouse and children**
- **A plan that meets ACA affordability and minimum value standards**
- Even with employer coverage, you may still qualify for Marketplace savings based on your household income.

Need Help?
Contact your HR department for plan details or visit HealthCare.gov for Marketplace information.

Medicare Part D Creditable Coverage Notice
Federal law requires employers to notify Medicare-eligible individuals whether their prescription drug coverage is creditable—meaning it is expected to pay, on average, as much as standard Medicare Part D prescription coverage.

Why This Matters:
If you're eligible for Medicare and do not have creditable drug coverage, you may face a late enrollment penalty if you delay enrolling in Medicare Part D and go without creditable coverage for 63 days or more.

SUMMARY ANNUAL NOTICES

What Is Creditable Coverage?
Prescription drug coverage is considered creditable if it is expected to pay, on average, as much as Medicare Part D. Coverage that pays less is non-creditable.

Important for Groups Offering Multiple Plans:
If your employer offers multiple health plans, some plans may be creditable, some non-creditable, or a mix. It is essential to review your specific plan's status each year and choose coverage that aligns with your Medicare needs if you're eligible or nearing eligibility. Below is a list of the plans available and Medicare Part D status:

FEHB Medical Plan Creditable

What You Should Do:
If you are Medicare-eligible (or will be soon), review the notice provided for your specific plan.
Keep the notice for your records — you may need to show proof of creditable coverage to avoid penalties.
Contact HR or your benefits administrator if you're unsure which plan you're enrolled in or need help understanding the creditable status.

For more information about Medicare Part D, visit: https://www.medicare.gov

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

MHPAEA mandates that mental health and substance use disorder benefits cannot have more restrictive limits than general medical/surgical benefits.

Key Points:
- Plans cannot apply higher co-pays, deductibles, or limits on visits for mental health/substance use or disorder treatments.
- For more details about coverage and medical necessity determinations, contact your plan administrator.

For more information please visit:
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mhpaea

MICHELLE'S LAW

Under Michelle's Law, a dependent child can remain covered by the health plan for up to one year while on a medically necessary leave of absence from a post-secondary institution due to illness or injury.

Key Requirements:
The dependent must provide written certification from a physician confirming that the leave is medically necessary.

For more information please contact your health plan administrator.

SUMMARY ANNUAL NOTICES

Newborns' and Mothers' Health Protection Act

Federal law prohibits group health plans from limiting hospital stays following childbirth to less than:

- 48 hours after a vaginal delivery
- 96 hours after a cesarean section

For more information please visit - dol.gov/agencies/ebsa/laws-and-regulations/laws/nmhpa

Protection Against Surprise Medical Bills

Balance Billing (surprise billing) occurs when you receive care from an out-of-network provider at an in-network facility or in an emergency.

Key Protections:

- **Emergency Services**: You are only responsible for your in-network cost-sharing.
- **In-Network Facility Services**: Out-of-network providers at in-network hospitals cannot balance bill.
- **Written Consent**: You can waive these protections with written consent.

For help with surprise billing, contact the No Surprises Help Desk at 1-800-985-3059 or visit cms.gov/nosurprises/consumers.

Notice of Patient Protections

You have the right to:

- **Primary Care Provider (PCP)**: Choose any participating PCP in the network, including pediatricians for children.
- **Obstetric and Gynecological Care**: No prior authorization is needed for obstetrics or gynecology services from network providers.

For more information please visit – www.healthcare.gov

Notice of Privacy Practices

This notice outlines your rights regarding your medical information:

- **Access to Records**: You can request copies of your health and claims records.
- **Correct Records**: You can request corrections if records are inaccurate.
- **Confidential Communication**: You can request confidential ways to communicate with you.
- **Limit Sharing**: You can restrict sharing your information for treatment, payment, and operations.

For more details or to file a complaint please contact your health plan administrator.

USERRA Notice Summary

(Uniformed Services Employment and Reemployment Rights Act)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), employees who leave their job to perform military service have the right to be reemployed in their civilian job and retain certain benefits upon their return.

Key Rights Under USERRA:

- **Reemployment Rights:** If you leave your job for military service, you are generally entitled to return to your job with the same seniority, status, and pay, provided:
    - You give advance notice of service (when possible)
    - Your cumulative military service is 5 years or less with the same employer
    - You return to work within the required time frame after completing service

SUMMARY ANNUAL NOTICES

Key Rights Under USERRA Con't

- **Health Insurance Protection:**
  - You may elect to continue your employer-sponsored health coverage for up to 24 months while on military leave.
  - If you choose not to continue coverage, your health plan coverage will be reinstated without waiting periods upon your return.

- **Pension and Retirement Plans:**
  - Time spent on military duty is treated as service with the employer for vesting and benefit accrual purposes.

Questions or Claims?
If you believe your USERRA rights have been violated, contact:
U.S. Department of Labor, Veterans' Employment and Training Service (VETS)
1-866-4-USA-DOL (1-866-487-2365)
www.dol.gov/vets

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment & Annual Notice
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that requires group health plans and insurance issuers that cover mastectomies to also provide reconstructive surgery and related benefits.
What the Law Requires:
If you or a covered dependent receive benefits for a mastectomy, your plan must also cover the following services, as requested by the patient and their physician:

- Reconstruction of the breast removed by mastectomy
- Surgery and reconstruction of the other breast for a symmetrical appearance
- Prostheses (artificial breast devices)
- Treatment of physical complications, including lymphedema

Important Notes:

- These benefits are subject to the same deductibles and coinsurance as other medical/surgical benefits under your plan.
- WHCRA applies to both women and men covered by the plan who undergo a mastectomy.

For more general information, visit the U.S. Department of Labor's WHCRA page:
dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra

SUMMARY ANNUAL NOTICES

Reproductive Health Care Privacy Attestation:

Certain states require employers and health plans to provide a notice regarding privacy protections for reproductive health care information.

What This Means:
Your employer or health plan attests that it does not request, collect, or share your reproductive health care information unless required by law or necessary for providing your benefits.
You have privacy rights related to your reproductive health care under applicable state and federal laws.
This attestation confirms the employer's commitment to maintaining the confidentiality of your reproductive health care information.

What You Should Know:
If you have concerns or questions about your reproductive health care privacy, you may contact your Human Resources (HR) department.

Disclaimer:

This summary is intended for informational purposes only and does not include all details of the applicable laws. If you would like a copy of the full legislation or need more detailed information about any of the notices summarized above, please contact your Human Resources (HR) department.

NOTES