2026 Benefits Guide 3939

Spokane Transit

CONTENTS

GETTING STARTED

MEDICAL, DENTAL & VISION

ENGAGE IN YOUR HEALTH

LIFE & DISABILITY

VOLUNTARY BENEFITS

IMPORTANT PLAN INFORMATION

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

PLAN CONTACTS

STA HUMAN RESOURCES

lduffin@spokanetransit.com

(509) 344-1880

Benefit Advocate

jessica.russo@alliant.com

(509) 343-9516

MEDICAL

Kaiser Permanente

(888) 901-4636

Premera Blue Cross

(800) 722-1471

DENTAL

Delta Dental of Washington

(800) 554-1907

HRA VEBA

www.hraveba.org

(888) 659-8828

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA) & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

www.hraveba.org

(888) 338-4415

LIFE, AD&D & LTD

USAble

www.usablelife.com

(800) 370-5856

GETTING STARTED

2026 BENEFITS

January 1, 2026
through
December 31, 2026

MEDICARE PART D NOTICE

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

Welcome to your 2026 benefits. Our benefits program provides you with the best in coverage that is simple and easy to use. We offer programs that protect your health, your money, your family, and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so you know how to get care, when you need it, at the lowest cost. With the information and tools in this guide and related resources, we hope to help you be well today and work toward a healthy and secure future.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a full-time employee working 80+ hours per month.

Eligible dependents

- Legally married spouse (including same-sex spouse)
- Natural, adopted or stepchildren up to age 26
- Tax dependents over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents and siblings who are not your tax dependents as described above are not eligible for coverage. In addition, an employee of Spokane Transit Authority cannot be covered as both an employee and a dependent of another employee (for example, a spouse).

Dependent eligibility and verification process

Who are Eligible Dependents?

- Eligible dependents include your legal spouse, your legally recognized domestic partner and eligible children up to age 26
- Coverage may be available to eligible children regardless of student, residential or marital status; however, if your child is married, the spouse and/or children of that child is not eligible
- Eligible dependents may also include children whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support order
- Children placed for adoption - Placement for adoption is the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final
- A child may be your biological, step, adopted, or children of your legally recognized domestic partner
- It also includes dependent unmarried children of any age who are physically or mentally challenged if they were enrolled in a Spokane Transit Health Plan and became disabled prior to turning 26 years of age

Who is not eligible for Spokane Transit coverage?

- Ex-spouses, even with a Qualified Domestic Relations Order requiring you provide health insurance coverage
- Former stepchild of an ex-spouse
- Extended family members, including mother, father, siblings, grandparents, grandchildren, in-laws, etc., under any circumstances
- A child who is your extended family member – grandchild, niece, nephew except when you are the "legal" guardian as established by a court of law
- Children Over age 26 years of age if they were not enrolled in a plan prior to becoming mentally or physically disabled
- Children placed for adoption when legal obligations are terminated

About dependent verification

Dependent verification helps make sure the Spokane Transit Authority medical and dental program covers only people who qualify. If you want to add family members to your coverage, you must provide verification documents to show they're eligible before they can be enrolled under your coverage.

You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and certified by a notary public.

Use the list(s) below to determine which verification document(s) you need to submit with your enrollment form(s). If you submit a tax return, you may submit just one copy if it includes all family members that require verification, such as your spouse and children. Submit the documents along with your enrollment form(s) within Spokane Transit Authority's enrollment timelines.

To enroll a spouse

Provide a copy of (choose one):

- Most recent year's 1040 Married Filing Jointly federal tax return that lists the spouse (black out financial information)
- Subscriber's and spouse's most recent 1040 Married Filing Separately federal tax return (black out financial information)
- Proof of common residence (example: a utility bill) and marriage certificate*
- Valid J-1 or J-2 visa issued by the U.S. Government

*If within two years of marriage, only the marriage certificate is required.

To enroll a state-registered domestic partner or legal union partner

Provide a copy of (choose one):

- Proof of common residence (example: a utility bill) and certificate/card of state-registered domestic partnership*
- Proof of financial interdependency (example: a shared bank statement - black out financial information) and certificate/card of state-registered domestic partnership*
- Valid J-1 or J-2 visa issued by the U.S. Government

*If within two years of state-registered domestic partnership, or establishment of a legal union from another jurisdiction as defined in statute, only the certificate/card of state-registered domestic partnership or legal union is required.

To enroll children

Provide a copy of (choose one):

- Most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter (black out financial information)

Note: You can submit one copy of your tax return if it includes all family members that require verification.

- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by U.S. Government

**If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling the spouse or state-registered domestic partner in STA's insurance coverage.

For Foreign Nationals

- Must provide current visa documentation showing marriage, (Social Security and financial information should be blacked out)
- Must provide current visa documentation showing date of birth of a child

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following 60 days of employment. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

Outside of open enrollment, you may be able to add or remove dependents or change benefit options if you have a big change in your life and submit your change within 30 days. Eligible events include:

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

MEDICAL

OUR PLANS

PPO

Preferred Provider Option

- Premera Medical PPO
- Kaiser Medical Access PPO CDHP

HMO

Health Maintenance Organization

- Kaiser Medical HMO Buy-Up Plan
- Kaiser Medical HMO Core Plan

Check the network

Do you prefer specific doctors or hospitals? Visit the plan's website to find out if they are in-network. If not, you'll pay a bigger share of the cost.

WHICH PLAN IS RIGHT FOR YOU?

Spokane Transit Authority offers different medical plans for needs and budgets. Here's an overview of how each type of plan work.

- A PPO gives you flexibility and choice, for a price. You can go to any doctor without a referral, but you will pay a larger share of the cost if they are not in the plan's network. You'll need to meet an annual deductible before the plan starts to pay.
- An HMO gives you more predictable costs but less flexibility. You pay a copay for most services, but all care must be received within the HMO network. Out-of-network care is not covered except in an emergency. You may need to meet a deductible before the plan starts to pay. You must choose a primary care physician (PCP) to manage routine care, referrals, and hospital stays. Kaiser plans are unique in that you do not have to select a PCP, and you must receive all care at Kaiser facilities.

Evaluate your needs

Do you... visit a chiropractor? ...have frequent doctor or urgent care visits? ...get ongoing tests? ...take medications? ...have surgery planned? Compare these costs under each plan.

2026 Premera Blue Cross Medical Option

Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

Benefits	In-Network Benefits	Out-of-Network Benefits
Annual deductible	$250 per individual; $750 family limit	
Annual out-of-pocket maximum	$2,000 per individual; $4,000 family limit	Not applicable
Primary provider office visit	Plan pays 85% after deductible	Plan pays 60% after deductible
Specialist office visit	Plan pays 85% after deductible	Plan pays 60% after deductible
Chiropractic care (up to 10 visits per year)	Plan pays 85% after deductible	Plan pays 60% after deductible (in-network limitations apply)
Preventive care	Plan pays 100% (see contract for limitations)	Not covered
Diagnostic lab and X-ray	Preventive: plan pays 100% All other: plan pays 85% after deductible	Plan pays 60% after deductible (see contract for limitations)
Urgent Care	Plan pays 85% after deductible	Plan pays 60% after deductible
Emergency Room (copay waived if admitted)	$75 copay then plan pays 85% after deductible	
Hospitalization	1st 3 days: $200 copay per day then plan pays 85% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 85% after deductible	Plan pays 60% after deductible
PRESCRIPTION DRUGS		
Annual deductible	$100 (up to $300 per family)	Combined with in-network
Generic	Plan pays 90%	Pharmacy: cost share then plan pays 60% (of allowable) Mail order: Not covered
Preferred brand	Plan pays 70% after Rx deductible	Pharmacy: cost share then plan pays 60% (of allowable) after Rx deductible Mail order: not covered
Non-preferred brand	Plan pays 50% after Rx deductible	Pharmacy: cost share then plan pays 60% (of allowable) after Rx deductible Mail order: not covered
Number of days supply	Pharmacy: 30 days Mail order: 90 days	Pharmacy: 30 days Mail order: Not applicable
ADULT VISION – Members 19 and Older		
Copay	Exam: Plan pays 100% Materials: Plan pays 100% (reimbursed up to $200)	Exam: Plan pays 60% after deductible Materials: Plan pays 100% (in-network limitation apply)
Frequency	Exam: Once every calendar year; Materials: Once every calendar year	Exam/Materials: In-network limitations apply
PEDIATRIC VISION – Under 19		
Copay	Exam: Plan pays 85% after deductible Materials: Covered in full (1 pair of frames & lenses)	
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year	

2026 Kaiser Permanente Medical CDHP

Medical Access PPO Consumer Health Driven Plan (CDHP)

Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$1,700 per individual; $3,400 family limit	$3,400 per individual; $6,800 family limit
Annual Out-of-Pocket Maximum	$4,200 per individual; $6,850 family limit	Not applicable
PCP office visit Specialist office visit	Plan pays 85% after deductible	Plan pays 60% after deductible
Chiropractic Up to 15 visits per year	Plan pays 85% after deductible	Plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	Preventive: 100%; all other: Plan pays 85% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 85% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 85% after deductible	Plan pays 85% after deductible
Hospitalization	Plan pays 85% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 85% after deductible	Plan pays 60% after deductible
PRESCRIPTION DRUGS		
Deductible	Prescriptions subject to medical plan deductible	Not applicable
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximum	Not applicable
Generic Preferred generic Preferred brand Non-preferred brand	Pharmacy: 85% after deductible KP Pharmacy: 95% after deductible Mail order: 2x above cost shares	Not covered
Number of days supply	Pharmacy: 30 days Mail order: 90 days	Not applicable
ADULT VISION – Members 19 and Older		
Copay	Exam: plan pays 100% Materials: plan pays 100% (reimbursed up to $200)	
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year	
PEDIATRIC VISION – Under 19		
Copay	Exam: plan pays 100% Materials: covered in full (1 pair of frames & lenses)	
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year	

2026 Kaiser Permanente Buy Up Plan

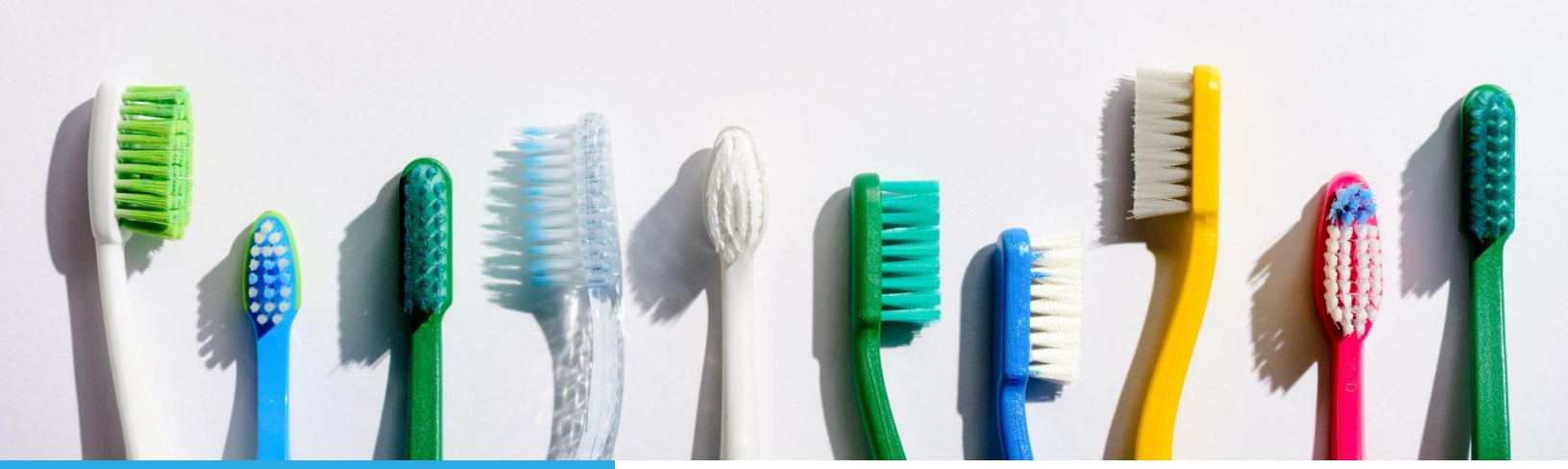
Kaiser Permanente Medical HMO Core Buy-Up Plan

Benefits	In-Network Only
Annual deductible	$250 per individual; $500 family limit
Annual out-of-pocket maximum	$2,000 per individual; $4,000 family limit
Primary provider office visit	$15 copay then plan pays 100% after deductible
Specialist office visit	$30 copay then plan pays 100% after deductible
Chiropractic care (up to 10 visits per year)	$15 copay then plan pays 100% after deductible
Preventive care	Plan pays 100% (see contract for limitations)
Diagnostic lab and X-ray	Preventive: plan pays 100% Complex imaging: $30 copay then 100% after deductible All other: plan pays 100% after deductible
Urgent Care	$15 copay then plan pays 100% after deductible
Emergency Room (copay waived if admitted)	$250 copay then 100% after deductible
Hospitalization	1st 5 days: $150 copay per day then plan pays 100% after deductible
Outpatient Surgery	Plan pays 100% after deductible
PRESCRIPTION DRUGS	
Annual out-of-pocket maximum	Prescriptions subject to medical out-of-pocket maximum
Preferred generic	Pharmacy: $20 copay then plan pays 100% Mail order: $40 copay then plan pays 100%
Generic	Pharmacy: value based drugs: $5 copay then plan pays 100% Mail order: value based drugs: $10 copay then plan pays 100%
Preferred brand	Pharmacy: $40 copay then plan pays 100% Mail order: $80 copay then plan pays 100%
Non-preferred brand	Pharmacy: plan pays 50% up to $250 Mail order: plan pays 50% up to $750
Number of days supply	Pharmacy: 30 days Mail order: 90 days
ADULT VISION – Members 19 and Older	
Copay	Exam: $15 copay then plan pays 100% Materials: plan pays 100% (reimbursed up to $200)
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year
PEDIATRIC VISION – Under 19	
Copay	Exam: $15 copay then plan pays 100% Materials: covered in full (1 pair of frames & lenses)
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year

2026 Kaiser Permanente Medical Core Plan

Kaiser Permanente Medical HMO Core Plan

Benefits	In-Network Only
Annual deductible	$350 per individual; $700 family limit
Annual out-of-pocket maximum	$2,000 per individual; $4,000 family limits
Primary provider office visit	$20 copay then plan pays 100% after deductible
Specialist office visit	$40 copay then plan pays 100% after deductible
Chiropractic care (up to 10 visits per year)	$20 copay then plan pays 100% after deductible
Preventive care	Plan pays 100% (see contract for limitations)
Diagnostic lab and X-ray	Preventive: plan pays 100% Complex imaging: $40 copay then 100% after deductible; All other: plan pays 100% after deductible
Urgent care	$20 copay then plan pays 100% after deductible
Emergency room (copay waived if admitted)	$300 copay then plan pays 100% after deductible
Hospitalization	1st 5 days: $200 copay per day then plan pays 100% after deductible
Outpatient Surgery	Plan pays 100% after deductible
PRESCRIPTION DRUGS	
Annual out-of-pocket maximum	Prescriptions subject to medical out-of-pocket maximum
Preferred generic	Pharmacy: $20 copay then plan pays 100% Mail order: $40 copay then plan pays 100%
Generic	Pharmacy: value based drugs: $5 copay then plan pays 100% Mail order: value based drugs: $10 copay then plan pays 100%
Preferred brand	Pharmacy: $40 copay then Plan pays 100% Mail order: $80 copay then Plan pays 100%
Non-preferred brand	Pharmacy: plan pays 50% up to $250 Mail order: plan pays 50% up to $750
Number of days supply	Pharmacy: 30 days Mail order: 90 days
ADULT VISION – Members 19 and Older	
Copay	Exam: $20 copay then plan pays 100% Materials: plan pays 100% (reimbursed up to $200)
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year
PEDIATRIC VISION – Under 19	
Copay	Exam: $20 copay then plan pays 100% Materials: covered in full (1 pair of frames & lenses)
Frequency	Exam: 1 x every calendar year Materials: 1 x every calendar year



DENTAL

2026 Delta Dental of Washington PPO Plan			
BENEFITS	**Delta PPO Dentists**	**Delta Premier Dentists**	**Non-Participating[2]**
Annual Deductible	$50 per individual / $150 per family		
Annual Plan Maximum[1]	$2,000 per individual		
Diagnostic & Preventive (exams, cleanings, x-rays, sealants, fluoride)	Plan pays 100%	Plan pays 90%	Plan pays 80%
Basic Services (fillings, root canals, periodontics, oral surgery)	80% after deductible	80% after deductible	70% after deductible
Major Services (dentures, implants, bridges, crowns)	50% after deductible	50% after deductible	40% after deductible
Orthodontia	50%		
Lifetime maximum	$2,000 per individual		

[1]$2,000 annual maximum is combined across all networks
[2]When using an out-of-network provider, you may be responsible for balanced billing charges. For the most savings, visit a PPO or Premier Delta Dental provider

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) VEBA

Your “allowance” for healthcare expenses

Healthcare can be expensive. That’s why Spokane Transit provides you with an HRA VEBA to help pay your medical expenses. The account is administered by HRAVEBA.

Here’s how it works

Spokane Transit deposits $25 in your HRA VEBA each month.

You can use this money for yourself or any eligible family member.

When you have expenses for medical, dental, vision or prescriptions such as deductibles, copays or coinsurance, you can use your HRA debit card or submit a request for reimbursement with a detailed receipt or Explanation of Benefits. You can also use your HRA VEBA account to reimburse yourself for some approved over-the-counter healthcare expenses.

Two reasons to love an HRA

1. It’s 100% employer-funded. All contributions are made by Spokane Transit. In fact, the rules prohibit employee contributions.
2. There is not “use it or lose it”. Unused money rolls over to use in future years.

Spokane Transit's Consumer Driven Health Plan (CDHP) additional VEBA contribution - an option for ATU 1598, M&A and AFSCME 3939 only

Spokane Transit is pleased to offer the option of a Kaiser Permanente High Deductible Consumer Driven Health Plan (CDHP) in conjunction with our current VEBA Health Reimbursement Arrangement. This plan is currently offered to the M&A (non-rep) group and members of ATU 1598 & AFSCME 3939.

VEBA Contributions for 2026

When you enroll in the Kaiser Permanente CDHP, Spokane Transit will contribute $1700 for employee only overage, or $3400 for employee plus dependent(s), into your HRA VEBA account. This is in addition to your regular VEBA contribution.

The contribution is pro-rated monthly over the year:

Individuals covered on CDHP	Monthly deposit into VEBA	Total deposited for a full calendar year
Just you	$141.66/mo.**	$1700
You and your family*	$283.33/mo.***	$3300

*if you have at least one family member on your CDHP, you qualify for the family contribution.
**$141.74 in December
***$283.37 in December
Note: The entire amount is **not** available on January 1.

Why might this plan option be the right choice for you?

- It **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like throwing money out the window. CDHPs come with much lower premiums than a traditional PPO health plan, meaning less money is deducted from your paychecks.

- You can use your HRA VEBA to pay **qualified medical expenses**, COBRA benefits, retiree medical premiums, Medicare premiums or long-term care.

For more information, please contact Lisa in Benefits at 509-344-1880 or email HRHelpDesk@spokanetransit.com

PREVENTIVE CARE

WHAT PREVENTIVE CARE DO YOU NEED?

Visit healthfinder.gov and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

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

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

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible.

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

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

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

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

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

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

STA-PROVIDED LIFE AND AD&D INSURANCE

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company and provided by USAble.

Employees can elect to purchase additional Life and AD&D insurance, which is 100% employee paid.

USABLE BASIC LIFE AND AD&D PLAN	
Employee Coverage	
Life Amount:	$25,000
AD&D Amount:	$5,000

LONG-TERM DISABILITY INSURANCE (LTD)

LTD benefits cushion the financial impact of a disability:

Salary replacement insurance if you are off work with a qualifying disability. Premiums are paid 50% by STA and 50% by you.

USABLE LONG TERM DISABILITY	
Employee Coverage	
Monthly benefit:	60% of covered monthly earnings up to a maximum of $4,000
Benefits begin:	After 90 days of disability

3 THINGS TO KNOW ABOUT LTD INSURANCE

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

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Healthcare Flexible Spending Account (FSA)
- Dependent Care FSA
- Nationwide Pet Insurance
- AFLAC

You're unique—and so are your benefit needs

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

Spokane Transit Authority offers plans to help:

- provide income for survivors
- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- save money on protection for your pets,
- You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

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

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Set aside healthcare dollars for the coming year

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

How the FSA plan works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to $1,800 Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

You will have a 2 ½ month grace period after the calendar year. Any additional remaining balance will be forfeited at that time.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

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

Dependent Care FSA—up to $7,500 per year tax-free

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

Here's how the plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children younger than 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

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

Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%[1]
- **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®

50% reimbursement

$20-$35/month[2]

70% reimbursement

$27-$47/month[2]

How to use your pet insurance plan

1. Visit any vet, anywhere.
2. Submit claim.
3. Get reimbursed for eligible expenses.

Visit us at: petinsurance.com/spokanetransit

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

[2]Starting prices indicated. Final cost varies according to plan, species and ZIP code.

Nationwide®

Open to 1598, 3939 and non-represented only

Spokane Transit Authority
Voluntary Benefits

Spokane Transit Authority partners with Aflac giving you the chance to choose the products and services that best meet you and your family's needs.

Health insurance pays doctors and hospitals. Aflac pays YOU directly to help pay the bills health insurance doesn't cover.

The following plans are available during this enrollment - no health questions asked:

- **Group Accident Insurance** helps pay costs that arise from covered accidents such as fractures, dislocations and lacerations. This plan provides 24-hour coverage, which means you're covered at home and at work. **Cost: $6.38 per paycheck (24 paychecks)**
- **Group Critical Illness Insurance** helps pay the expected and unexpected expenses that arise from diagnosis of a covered critical illness such as cancer (internal or invasive), heart attack, stroke, end-stage renal failure or a major organ transplant. This plan includes a $50 Health Screening Benefit for the covered employee and spouse only.
  Cost: starting at $3.24 per paycheck (24 paychecks)
- **Group Hospital Indemnity Insurance** helps pay costs for a covered hospital stay, including benefits for hospital confinement, admission and hospital intensive care. The plan also includes a $50 Health Screening Benefit for each covered insured. **Cost: $10.39 per paycheck (24 paychecks)**

Additional Free Services come with the purchase of an Aflac policy!

Contact your Local Aflac Rep:
Ken Allen
509.879.5366
terry_allen@us.aflac.com

Alliant

IMPORTANT PLAN INFORMATION

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

- Your medical, dental, and vision benefit contributions for the 2026 plan year
- A summary of the health plan notices you are entitled to receive annually, and where to find them

YOUR MONTHLY BENEFIT COSTS

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

PREMERA YOUR CHOICE	Total Monthly Premium	Employer Monthly Cost	Your Monthly Cost	Your Bi-Weekly Cost
Employee Only	$1,231.24	$1,108.12	$123.12	$61.56
Employee + Spouse	$2,462.59	$2,093.21	$369.38	$184.69
Employee + Child(ren)	$2,175.56	$1,863.58	$311.98	$155.99
Employee + Family	$3,406.87	$2,848.63	$558.24	$279.12

KAISER PPO CDHP PLAN	Total Monthly Premium	Employer Monthly Cost	Your Monthly Cost	Your Bi-Weekly Cost
Employee Only	$668.31	$634.89	$33.42	$16.71
Employee + Spouse	$1,336.62	$1,202.96	$133.66	$66.83
Employee + Child(ren)	$1,182.91	$1,072.31	$110.60	$55.30
Employee + Family	$1,851.22	$1,640.38	$210.84	$105.42

KAISER HMO BUY UP PLAN	Total Monthly Premium	Employer Monthly Cost	Your Monthly Cost	Your Bi-Weekly Cost
Employee Only	$808.19	$767.79	$40.40	$20.20
Employee + Spouse	$1,616.38	$1,454.76	$161.62	$80.81
Employee + Child(ren)	$1,430.50	$1,296.76	$133.74	$66.87
Employee + Family	$2,238.69	$1,983.73	$254.96	$127.48

YOUR MONTHLY BENEFIT COSTS (Continued)

KAISER HMO CORE PLAN	Total Monthly Premium	Employer Monthly Cost	Your Monthly Cost	Your Bi-Weekly Cost
Employee Only	$689.25	$654.79	$34.46	$17.23
Employee + Spouse	$1,378.50	$1,240.66	$137.84	$68.92
Employee + Child(ren)	$1,219.97	$1,105.91	$114.06	$57.03
Employee + Family	$1,909.22	$1,691.76	$217.46	$108.73

DELTA DENTAL PPO PLAN	Total Monthly Premium	Employer Monthly Cost	Your Monthly Cost	Your Bi-Weekly Cost
Composite	$102.91	$97.77	$5.14	$2.57

A Note about Domestic Partners

Imputed Income

Domestic Partners will not receive tax favored employer sponsored group health plan benefits under Federal or State law. This means that Domestic Partners will have the Fair Market Value (FMV) of coverage imputed as income under Federal and State law (there are State Exceptions). Note that the term Domestic Partner can refer to registered Domestic Partners recognized by state law and confirmed by registration with the state, as well as Domestic Partners that are simply recognized in an employer's plan eligibility provisions and usually confirmed by employee affidavit. Same sex spouses are now legally recognized under Federal and State law and are different from Domestic Partners.

After-tax deductions

Please note that unless your domestic partner is also your tax- dependent as defined by the IRS, contributions for domestic partner coverage must be made on an after-tax basis. Similarly, the company contribution toward the cost of domestic partner coverage and his/her dependents is taxable income to you. Contact your tax advisor for more details on how this tax treatment applies to your specific situation. Contact Human Resources directly if your domestic partner is also your tax dependent.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

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

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available through Employee Navigator, on the STA website or upon request by contacting Human Resources at (509) 344-1880.

- Kaiser Permanente Medical HMO Core Buy-Up Plan
- Kaiser Permanente Medical HMO Plan
- Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)
- Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

STATEMENT OF MATERIAL MODIFICATIONS

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

PLAN DOCUMENTS

Important documents for our health plan are available in the Annual Notices section of this guide. Additional copies of these documents and notices are available if requested. If you would like a paper copy, please notify STA Human Resources **lduffin@spokanetransit.com or** (509) 344-1880.

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

ANNUAL NOTICES

Medicare Part D Notice

Important Notice from Spokane Transit Authority About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Spokane Transit Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Spokane Transit Authority has determined that the prescription drug coverage offered by the following plans 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.

- Kaiser Permanente Medical HMO Core Buy-Up Plan
- Kaiser Permanente Medical HMO Plan
- Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)
- Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your Spokane Transit Authority coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the plans listed below are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

- Kaiser Permanente Medical HMO Core Buy-Up Plan
- Kaiser Permanente Medical HMO Plan
- Kaiser Permanente Medical Access PPO Consumer Health Driven Plan (CDHP)
- Premera Blue Cross Medical PPO Your Choice 250 Heritage Plus 1 Plan

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Spokane Transit Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. 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 Spokane Transit Authority changes. You also may request a copy of this notice at any time.

- Kaiser Permanente: (888) 901-4636
- Premera Blue Cross: (800) 722-1471

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	01/01/2026
Name of Entity:	Spokane Transit Authority
Contact-Position/Office:	Lisa Duffin
Address:	1230 W. Boone Spokane, WA 99201
Phone Number:	(509) 344-1880

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (509) 344-1880.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (509) 344-1880.

HIPAA Notice of Special Enrollment Rights

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

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

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

The 'No Surprises' Rules

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

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

View a sample notice and consent form (PDF).

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

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, 2025. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en _US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

General Notice of COBRA Continuation Coverage Rights

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Premera Blue Cross or Kaiser Permanente and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Name of Entity:	Spokane Transit Authority
Contact-Position/Office:	Lisa Duffin
Address:	1230 W. Boone Spokane, WA 99201
Phone Number:	(509) 344-1880

Spokane Transit