2026 OPEN ENROLLMENT

The annual open enrollment period is the one time of year that you can change your benefit elections without needing a qualified life event. This Guide provides a brief description of the benefit plans available to you and your family members. Please read it carefully, since understanding the options available to you can help ensure that you choose the right benefit options for you and your family.

MEDICAL & VISION PLANS

- We are renewing our medical plans with Regence BlueShield. We are introducing a third plan option that will allow for a lower cost medical plan that offers copays.
- You have the ability to choose in which plan you wish to enroll. Each plan has slightly different benefits, so we encourage you to review the Benefits Guide as well as the Benefit Summaries and SBCs for more information.
- We are continuing the vision coverage with Regence BlueShield. It is bound to the medical coverage, so anyone enrolled in either medical plan will automatically be enrolled in vision coverage. There has been an enhancement to the vision benefits, so please review the Benefits Guide as well as the Benefit Summaries and SBCs for more information.

VOLUNTARY DENTAL PLAN

- We are moving our dental plan from Regence BlueShield to Reliance Standard effective 2/1/2026.
- Reliance Standard uses the Ameritas dental network, which is equivalent to (if not bigger in some areas) to the Regence network.
- The most of the benefits match the existing Regence dental coverage, though we always recommend reviewing the benefit summary for more information.

EMPLOYEE ASSISTANCE PROGRAM

- We will continue to offer the Employee Assistance Program to anyone enrolled in the Regence BlueShield medical coverage. This EAP is offered through ComPsych. More information is provided in the Benefits Enrollment guide and in the Open Enrollment materials.

SIMPLIFIED OPEN ENROLLMENT

CONSOLIDATED ENROLLMENT FORMS REQUIRED

- With the addition of the third medical plan, we are requesting that all eligible employees complete a new consolidated enrollment form. This will be used to confirm your elections and which medical plan you wish to enroll in.
- All eligible employees need to complete a Consolidated Enrollment Form and return it to Human Resources by **Friday, January 9, 2026**. This includes anyone waiving out of the benefits as well.

If you do not complete your enrollment during your designated window, you may not be able to enroll or make changes unless you experience a qualifying event, or until the next open enrollment period.

PACIFIC
FACILITY SOLUTIONS INC

EMPLOYEE BENEFIT GUIDE

February 1, 2026 through January 31, 2027

OVERVIEW

This Guide provides a brief description of the benefit plans available to you and your family members. Please read it carefully, since understanding the options available to you can help ensure that you choose the right benefit options for you and your family.

MEDICAL & VISION PLANS

- We offer three medical plans through **Regence Blue Shield**.
  - **Regence Blue Shield** offers a wide national network and additional benefits like virtual doctor visits and copays for chiropractic and acupuncture visits.
- The vision plan is linked to the medical plan, so anyone that is enrolled in the medical coverage will automatically receive the vision benefits.

DENTAL PLAN

- We offer voluntary dental coverage with **Reliance Standard**.
  - **Reliance Standard** uses the **Ameritas network** of dental providers, which is one of the larger networks in the state of Washington. Their coverage offers better benefits for using providers in their network as well as matching benefits for out of network providers, though with the possibility of balance billing. It is advisable to verify your provider's network status prior to receiving services.

WHO IS ELIGIBLE?

Full time employees are eligible to participate in benefit plans on the first day of the month following 60 days of full time employment. Full time employment is defined as working a minimum of 30 hours per week. Your eligible dependents include your legal spouse, and dependent children. Dependent children are eligible to age 26.

INITIAL ENROLLMENT

CONSOLIDATED ENROLLMENT FORM REQUIRED

- Eligible employees who are initially eligible for coverage and who wish to sign up must complete a Consolidated Enrollment Form and return it to Human Resources.
- For those with other insurance and who are waiving coverage, you will need to complete the waiver section of the Consolidated Enrollment Form and return it—along with a copy of your insurance ID card—to Human Resources.

If you do not complete your enrollment during your designated window, you may not be able to enroll or make changes unless you experience a qualifying event, or until the next open enrollment period.

ANNUAL OPEN ENROLLMENT

The annual open enrollment period allows you to make changes to your benefit plan elections and/or the family members you cover. Open Enrollment is normally conducted in early January of each year.

Elections you make during open enrollment will become effective February 1.

Changes can only be made *outside of the annual enrollment period* if you experience a qualified family status change that permits changes in your plan election.

MID-YEAR CHANGES

Unless you have a qualifying event, you cannot make changes to the benefits elections you make during your initial eligibility period or the annual Open Enrollment period. Benefit election changes without a qualifying event can be made during the next Open Enrollment period.

The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience certain life events that affect eligibility or family status. These events are referred to as qualifying events.

Qualified changes in status include (but are not limited to): Change in legal marital status; change in number of dependents; change in employment status of employee, spouse, or dependent; a dependent newly satisfies or ceases to satisfy eligibility requirements; change in place of residence; loss of certain other health coverage; court judgment, decree, or order; Medicare or Medicaid entitlement; significant cost or coverage changes; Family Medical Leave Act (FMLA) leave of absence; reduction of hours; Exchange/Marketplace enrollment.

If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if a qualifying event occurs.

If you experience a qualified "change in status," you must make enrollment or benefit changes that match the event within 30 days. For Medicare or Medicaid entitlement you must make changes within 60 days of the event. You have the right to elect coverage during the plan year if your or your dependent(s)' Medicaid/Children's Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) providing you request enrollment within 60 days of the loss of coverage or eligibility for premium subsidy.

Please note there are several conditions and/or limitations that apply to the events listed above.

Please contact Human Resources if you have any questions or believe you may qualify for an election change due to a qualifying event.

UNDERSTANDING HEALTH INSURANCE TERMINOLOGY

There are several terms that are used with almost every health insurance plan available. These terms can be quite confusing if you do not know the basics of what each term means and how they interact with each other. **Please refer to the benefit summaries for plan specifics**.

DEDUCTIBLE

The deductible is the amount of money you have to pay prior to your insurance plan paying benefits. What this actually means is that if you have a **$3,000** annual deductible, then you pay the first **$3,000** of services you receive each year (forgetting about copays). For instance, if you have surgery, the first **$3,000** that the doctors/hospital/surgery center bills will be your responsibility. You are required to pay your deductible on a calendar year basis (Jan 1 through Dec 31).

CO-INSURANCE

The co-insurance is the percentage that you pay for any billed amount AFTER you have met your deductible. The co-insurance percentage is usually written **70/30**, which means your insurance carrier pays **70%** of every dollar billed and you are responsible for the remaining **30%**. The co-insurance only applies after you have met your deductible and before you meet your out of pocket maximum.

OUT OF POCKET MAXIMUM

The Out of Pocket Maximum (**$7,150**) is the limit that you will pay during a calendar year for any/all medical services approved by the plan. Once this limit is reached, **you will not pay any copays, deductibles, or any other approved charges through the end of the calendar year** (as long as they stay on the plan).

COPAYS (CLASSIC 3000 & CLASSIC 1500 PLANS ONLY)

Copays are a set dollar amount that you pay for a specific service like physician office visits or prescription drugs. These specific services have the deductible waived, which means you only pay the copay for that particular service.

IMPORTANT CLARIFICATION — if you go to the doctor's office for an issue, that visit (you sitting in the office and talking to the doctor) is covered by that copay. If you have any other services done like lab work, x-ray or complex imaging, or anything else not normally covered in a "standard visit", those services are normally applied to your deductible and are NOT covered by the copay. See your plan for additional details.

MEDICAL PLAN

The medical plans are offered through **Regence BlueShield**. The following information is important to note about your medical plan coverage.

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

PPO plans allow you to choose to see PPO providers or non-network providers in the area or around the nation. Whenever possible, it is important to ask if a provider is In or Out of network with **Regence BlueShield's Preferred PPO network** prior to receiving services.

In-Network Providers

When you use a provider who participates in the **Regence BlueShield's Preferred PPO network,** your plan generally offers better benefits and lower out of pocket expenses. It is to your advantage to use PPO providers, but it is not required. Preventive Care services are also covered at 100% at in network providers.

Blue Card

- Your plan is a member of the national Blue Cross and Blue Shield network, which offers you "Blue Card" program access. This means that you can see any provider in the nation and receive in network benefits, as long as they are in network with their local Blue Cross/Blue Shield network.
- For example, if you went to an Urgent Care clinic in New Mexico, you would receive in network benefits as long as the clinic was in network with Blue Cross/Blue Shield of New Mexico.

In the United States

- Always carry your current member ID card.
- If you're a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.
- Call your BCBS company for precertification or prior authorization, if necessary. Refer to the phone number on the back of your member ID card.
- When you arrive at the participating doctor's office or hospital, show the provider your ID card. The provider will identify your benefit level through one of these symbols:

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay.
- Receive an explanation of benefits from your BCBS company.

In an emergency, go directly to the nearest hospital.

To locate doctors and hospitals wherever you or a covered dependent need care (have your member ID card handy):

- Visit the National Doctor & Hospital Finder at www.BCBS.com.
- Use the National Doctor & Hospital Finder app for Android,* iPhone, iPad and iPod Touch.** (Rates from your wireless provider may apply.)
- Call BlueCard Access® at 1.800.810.BLUE (2583).

Out of Network Providers

When you use a provider who does not participates in the **Regence BlueShield's Preferred PPO network,** your plan offers lower benefits than what you would receive at an in network provider. This can include paying a higher deductible, having a higher out of pocket annual maximum, and paying a larger cost share for out of pocket expenses.

MEDICAL PLAN

The medical plans are offered through **Regence BlueShield** . The following information is important to note about your medical plan coverage.

CHOOSING YOUR PLAN—PLAN TYPES

Pacific Facility Solutions offers two different types of medical plans and it is important to understand the differences between the two. Here is a general description of the two plans. Please see the Summary of Benefits and Coverage for more detailed plan information.

HEALTH SAVINGS ACCOUNT (HSA) QUALIFIED—HSA 3.0 3500 PLAN

- An HSA Qualified plan is a qualified high deductible health plan that does not provide first dollar coverage (outside of preventive services) prior to you meeting your annual deductible. This means that you generally pay the contracted cost for any services you have done, including doctor visits, prescriptions, lab work, x-rays, and surgeries.
- To be clear, if you go to the doctor's office or get a prescription, **you are responsible for 100% of the contracted/allowed cost** until you have met your deductible each calendar year. **There are NO COPAYS on this plan**.
- It is important to note that this is an **"embedded"** plan, which has implications for anyone enrolling dependents.
    - **If an employee enrolls anyone else (meaning spouse or dependent), the coverage changes from *employee only* to *family* coverage.**
    - **Anyone on family coverage must meet the FAMILY deductible of $7,000 before the co-insurance begins paying. This can be met using any combination of claims from anyone on the plan throughout the year.**
    - **The maximum anyone on the plan will pay out of pocket is $7,000 per calendar year.**
- These plans are designed to be partnered with a tax-free Health Savings Account (HSA) which allows you to contribute your own money on a pre-tax basis into the HSA.

TRADITIONAL COPAY PLANS — BASE CLASSIC 3000 & BUY UP CLASSIC 1500 PLANS

- In a traditional copay plan, the health insurance plan allows you many services for a fixed cost and "**waives the deductible**". This means that each doctor visit (regular, specialist, urgent care, or ER) or prescription comes with a set copay you will pay each time while Regence pays the difference in the cost.
- Any additional services (some lab work, x-rays, surgeries, or inpatient hospital stays) are subject to your calendar year deductible.
- These plans are generally best for those who are on monthly prescriptions, require monthly/quarterly doctor visits or lab tests, or who have chronic conditions that require ongoing treatments.

CONSIDERATION: PREVENTIVE SERVICES — ALL PLANS

- Preventive services are something to be included in your plan consideration.
- Under the Affordable Care Act, "Preventive Services" are covered at 100% under all of the plans offered. This means that the deductible or copays are waived and those qualifying services are paid 100% by **Regence BlueShield** at **in network** providers.
- There is an extensive list of preventive services, but some examples include:
    - **Immunizations** like COVID-19, MMR, Hepatitis, annual flu shots, DPT, etc.
    - **Birth Control** (including FDA approved methods, education, usage training)
    - **Tobacco Cessation** programs
    - Specific **lab tests** (when health history/demographics are met) like cholesterol, STD, some diabetes screenings, hepatitis screenings, etc.
    - Specific **procedures** (when health history/demographics are met) like cancer screenings, mammograms, sterilization, other screening types.
    - **Counseling/Examinations** (when health history/demographics are met) like blood pressure, depression, diabetes, obesity, STD, tobacco, alcohol/drug, etc.
    - Some **Preventive Medications** (when health history/demographics are met)

MEDICAL PLAN

The medical plans are offered through **Regence BlueShield**. The following information is important to note about your medical plan coverage.

CHOOSING YOUR PLAN—EMPLOYEE CHOICE

Pacific Facility Solutions offers three different medical plans and it is important to understand the differences between them. Here is a general description of the plans. Please see the Summary of Benefits and Coverage and Benefit Summaries for more detailed plan information.

EMPLOYEE CHOICE

- Regence's Employee Choice plans allow for employee agency in our medical benefits. By offering three plans, employees can choose which plan works best for them.
- Note—for anyone that changes plans, anything already credited to your calendar year deductible and out of pocket will automatically be applied to the new plan. Any claims incurred prior to 2/1 will be processed using the 2025-2026 plan benefits and any claims incurred on/after 2/1 will be processed using the new chosen plan benefits.

BASE COPAY PLAN — CLASSIC 3000

- This is a traditional copay plan which offers most services at a **$30 copay** (waiving the deductible).
- Lab work, radiology, outpatient procedures, and any inpatient stays will be subject to the deductible/ coinsurance.
- Virtual medical and mental health visits are available through the Doctor on Demand app for a **$10 copay** per visit.
- Preventive visits and services are covered at 100% at in network providers.
- **In simple terms, this plan would be the best for plan for anyone who wishes to utilize benefits like mental health, chiropractor/acupuncture, physical therapy, primary or specialist doctor visits, or have regular prescriptions**.

HSA PLAN—HSA 3.0 2500

- This is a qualified high deductible health plan that allows for contributions to an eligible Health Savings Account.
- **All services are subject to the deductible/coinsurance**.
- Virtual medical and mental health visits are available through the Doctor on Demand app, though there is a per visit cost (specified by the app) until the deductible/out of pocket maximum is met.
- Preventive visits and services are covered at 100% at in network providers.
- **In simple terms, this would be best for anyone specifically wishing to contribute their own funds into their HSA and who are not planning on utilizing benefits through the year.**

BUY UP COPAY PLAN — CLASSIC 1500

- This is a traditional copay plan which offers most services at a **$20 copay** (waiving the deductible).
- Lab work, radiology, outpatient procedures, and any inpatient stays will be subject to the deductible/ coinsurance.
- Virtual medical and mental health visits are available through the Doctor on Demand app for a **$10 copay** per visit.
- Preventive visits and services are covered at 100% at in network providers.
- **In simple terms, this plan would be the best for plan for anyone who is expecting major medical expenses or procedures in the next 12 months.**

MEDICAL PLAN

IN NETWORK BENEFITS	REGENCE BLUESHIELD CLASSIC 3000	REGENCE BLUESHIELD HSA 3.0 3500	REGENCE BLUESHIELD CLASSIC 1500
	BASE COPAY PLAN	HSA PLAN	BUY UP COPAY PLAN
Calendar Year Deductible	$3,000 Individual $9,000 Family	$3,500 Individual $7,000 Family [1]	$1,500 Individual $4,500 Family
Co-Insurance	You pay 30% Plan pays 70%	You pay 20% Plan pays 80%	You pay 20% Plan pays 80%
Calendar Year Out of Pocket Maximum	$7,150 Individual $14,300 Family	$7,000 Individual[2] $14,000 Family	$5,000 Individual $10,000 Family
	(Includes Deductible, RX Deductible, & Copays for the calendar year)		
OUTPATIENT SERVICES			
Preventive Care	You pay $0, Plan pays 100%	You pay $0, Plan pays 100%	You pay $0, Plan pays 100%
Virtual Visits	$10 Copay	Deductible, then you pay 10%	$10 Copay
Physician Office Visit	$30 Copay	Deductible, then you pay 20%	$20 Copay
Specialist Office Visit	$30 Copay	Deductible, then you pay 20%	$20 Copay
Chiropractic / Acupuncture Visit	$30 Copay Limits: 12 Chiropractic / 12 Acupuncture	Deductible, then you pay 20% Limits: 12 Chiropractic / 12 Acupuncture	$20 Copay Limits: 12 Chiropractic / 12 Acupuncture
Outpatient Mental Health Visit	$30 Copay	Deductible, then you pay 20%	$20 Copay
Urgent Care	$30 Copay	Deductible, then you pay 20%	$20 Copay
Emergency Room	$150 Facilities Copay All services subject to Deductible, then you pay 30%	Deductible, then you pay 20%	$150 Facilities Copay All services subject to Deductible, then you pay 20%
Outpatient Lab	Deductible, then you pay 30%	Deductible, then you pay 20%	Deductible, then you pay 20%
Imaging (Simple & Complex)	Deductible, then you pay 30%	Deductible, then you pay 20%	Deductible, then you pay 20%
Outpatient Procedures **Ambulatory Surgical Center**	Deductible, then you pay 30% Deductible, then you pay 20%	Deductible, then you pay 20% Deductible, then you pay 10%	Deductible, then you pay 20% Deductible, then you pay 10%
Prescription Drugs Tier 1 Tier 2 Tier 3 Specialty	 $10 Copay $35 Copay $75 Copay See above copays	 Deductible, then you pay 20% Deductible, then you pay 20% Deductible, then you pay 20% Deductible, then you pay 20%	 $10 Copay $35 Copay $75 Copay See above copays
INPATIENT SERVICES			
Inpatient Hospitalization, Surgeries, and Procedures	Deductible, then you pay 30%	Deductible, then you pay 20%	Deductible, then you pay 20%

The above benefit comparison shows In-Network benefits only. Refer to summaries for Out-of-Network benefits.

[1] - If enrolled in more than just employee only coverage for the HSA plan, the family deductible must be met before the plan begins paying.

[2] -If enrolled in more than just employee only coverage for the HSA plan, each family member is responsible for their own $7,000 out of pocket annual maximum until the overall family maximum has been met.

MEDICAL PLAN

VIRTUAL VISITS

Regence BlueShield partners with **Doctor on Demand** to offer primary care virtual doctor visits via the **Doctor on Demand** app. You can conduct "in person" video conference visits with a board certified, US based doctor 24 hours a day, 7 days a week, 365 days a year. The app works on your smart phone, tablet, or laptop.

The **Doctor on Demand** virtual visits offer consultation with a doctor who can diagnose and treat non-emergency medical conditions, prescribe medications, and send prescriptions to your preferred pharmacy. The doctors specialize in primary care, pediatrics, and family medicine.

Once you download the app and register, requesting a virtual visit is simple. The average wait time is between 5-15 minutes for the first available doctor. You are able to customize your profile to enter current medical conditions and prescriptions, medical history, and other valuable information you want the doctors to be aware of. Any medical records created by **Doctor on Demand** will be available to any other **Doctor on Demand** doctors you might see… but they are not normally provided to your primary care doctor without permission.

Common ailments treated via telehealth include:

All ages		Kids
Allergies	Pink eye	Cold & flu
Cold & flu	Rashes	Constipation
Ear infections	Sinus infection	Ear infections
Headache	Sore throat	Nausea
Infections	Sunburn	Pink eye

What you need to know

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

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

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

MEDICAL PLAN

REGENCE MENTAL HEALTH RESOURCES

Help is available. No referral is needed.

Thoughts of suicide? Call 988—National Suicide and Crisis Lifeline—available 24/7.

In-person care

Go to regence.com to find a doctor and look for these in-network options:

- Private practitioners with a variety of expertise, such as psychiatrists, psychologists, social workers, licensed counselors and more
- Inpatient care
- Outpatient programs

Virtual care

- **AbleTo Therapy+** for an 8-week series of one-on-one therapy with digital support between sessions for ages 18 and up: AbleTo.com or 1-866-287-1802
- **Array** specializes in psychiatry and counseling services for ages 5 and up: arraybc.com
- **Charlie Health** for an Intensive Outpatient Program treating ages 11 to 34 with behavioral health needs: charliehealth.com
- **Equip** for treatment of eating disorders for all ages: equip.health
- **NOCD** specializes in treatment of obsessive-compulsive disorders for ages 6 and up: treatmyocd.com
- **Talkspace** specializes in counseling for general behavioral health needs for ages 13 and up, and psychiatry/medication management for ages 18 and up: talkspace.com

Substance use disorder

- **Boulder Care** for virtual outpatient treatment: boulder.care or 1-866-901-4860
- **Eleanor Health** for in-person and virtual treatment: eleanorhealth.com or 1-866-402-7631
- **Hazelden Betty Ford** for inpatient and outpatient services. Virtual care is also available: hazeldenbettyford.org or 1-877-859-2124

Provider matching

- **Headway** for finding an in-network therapist and booking their next available virtual or in-person appointment for ages 6 and up: headway.co
- **Quartet** for getting a referral to an in-network behavioral health provider that meets your needs: Quartethealth.com

Employee Assistance Program (EAP)

Ask your HR team if your plan includes EAP. It quickly puts professional support in your hands without additional cost to you. Get a range of services to support your mental health, emotional well-being and life-balance needs.

Customer Service is here for you

Need more help finding the right care? Our compassionate team is ready to help. Just give us a call at the number on the back of your member ID card.

VOLUNTARY DENTAL PLAN

The dental plans are offered through **Reliance Standard**.

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

PPO plans provide you with the freedom to use a dentist of your choice or access the **Ameritas Classic Network** of dentists. If you use a dentist participating in the **Ameritas Classic Network**, your out-of-pocket expenses will be reduced, as fees are subject to a negotiated rate. If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.

It is recommended that any services in excess of $300 be sent to Reliance Standard for pre-determination before services are rendered.

BENEFITS	In and Out-of-Network
Calendar Year Deductible	$50 per individual Deductible is waived for Preventive Services
Calendar Year Plan Maximum	$1,500 per individual
CLASS I: PREVENTIVE SERVICES	
Routine Exam	You pay 0%, Plan pays 100%
Teeth Cleaning	You pay 0%, Plan pays 100%
Panoramic X-rays	You pay 0%, Plan pays 100%
CLASS II: BASIC SERVICES	
Simple Extraction	Plan deductible, then you pay 20% / the plan pays 80%
Fillings	Plan deductible, then you pay 20% / the plan pays 80%
Root Canal Endodontic	Plan deductible, then you pay 20% / the plan pays 80%
Periodontal Scaling	Plan deductible, then you pay 20% / the plan pays 80%
Oral Surgery	Plan deductible, then you pay 20% / the plan pays 80%
CLASS III: MAJOR SERVICES	
Dentures / Bridges	Plan deductible, then you pay 50% / the plan pays 50%
Inlays / Overlays	Plan deductible, then you pay 50% / the plan pays 50%
Crown	Plan deductible, then you pay 50% / the plan pays 50%

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

VISION PLAN

The vision plan is offered through **Regence BlueShield**.

The vision plan provide you with the freedom to use an eye doctor of your choice or access the **VSP Choice network** of providers. If you use a provider participating in the network, your out-of-pocket expenses will be reduced. If you use a non-network provider, in-network benefits and discounts will not apply and benefits will be paid according to a set benefit reimbursement schedule.

Extra Savings: In addition to the coverage below, the plan provides savings on additional pairs of glasses and sunglasses, retinal screening, and laser vision correction.

BENEFITS	REGENCE BLUESHIELD VISION PLAN	
	VSP CHOICE IN-NETWORK	OUT-OF-NETWORK
Eye Exams	$0 copay	Reimbursed up to $45
Hardware	$0 copay	Reimbursement Schedule Below
EYEGLASS LENSES AND FRAMES		
Single Standard Lenses	No Charge when **standard lenses** purchased from VSP provider	Reimbursed up to $30
Bifocal Standard Lenses		Reimbursed up to $50
Trifocal Standard Lenses		Reimbursed up to $65
Lenticular Standard Lenses		Reimbursed up to $100
Standard Frames	$250 VSP retail allowance OR $135 VSP approved wholesale 20% discount for additional complete pair of glasses	Reimbursed up to $70
CONTACT LENSES		
Evaluation and Fitting Exam	Up to $60 copay	Reimbursed up to $105
Elective Standard Contact Lenses	No Charge up to $250 when purchased from VSP provider	Combined reimbursement with evaluation and fitting exam
Please note: Contact Lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or other types of lenses until the next benefit period.		
FREQUENCY		
Eye Exam	Once every calendar year	
Lenses—Eyeglass or Contact	Once every calendar year	
Frames	Once every calendar year	
VSP LIGHTCARE		
Non-prescription sunglasses or blue light filter glasses	$250 VSP retail allowance OR $135 VSP approved wholesale	Reimbursed up to $70
Please note: VSP LightCare benefits are in lieu of all other frame, contacts, and lens benefits. When you receive the LightCare benefits, you will not be eligible for any frames, contacts, or other types of lenses until the next benefit period.		

2026 EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is offered through **ComPsych**. The EAP offers confidential support to help you meet life's challenges. A simple phone call connects you with a team of experienced professionals ready to assist you with a wide range of personal, family, and work issues. The EAP is available 24 hours a day, 7 days a week and includes face-to-face counseling visits, an unlimited number of phone consultations, assistance with financial and legal matters, and referrals to community resources. You are automatically enrolled in the plan and this benefit is provided at no cost to you.

Please note that these EAP benefits are available to you and anyone in your household, regardless of relationship to you.

ACCESS TO EAP SERVICES

Access to resources are available 24/7, 365 days a year. All you need to do is either call **800-922-2687** or access their website (www.guideanceresources.com). **You will need to use the code "EAPW" to register.**

MENTAL HEALTH ASSISTANCE

For anyone looking for mental health resources, **ComPsych** offers both online tools as well as assistance in finding an EAP provider who meets your specialty preference AND who is in network with your medical coverage (or best effort). This assistance includes finding a provider taking new patients as well as scheduling the initial visit and follow up after. In the event that the provider is not a good fit, **ComPsych** will assist in finding another provider. **ComPsych** will also cover the cost for the first **FOUR** visits per issue per person per year.

LEGAL SERVICES

Access a free 30-minute legal consultation, face-to-face, or by telephone. Should you decide to retain the attorney for ongoing services, you will receive a 25% reduction in the attorney's normal hourly fees. Workplace issues are excluded. Legal forms and templates are also available free on their website.

FINANCIAL SERVICES

Valuable resource offering expert advice and referrals to top-rated financial professionals. You have access to a free 30-days of phone consultations on topics like debt counseling, budgeting, college/retirement planning, and taxes. It also includes a 25% off discount on affiliated certified public accountant services for tax preparations.

ID THEFT AND FRAUD RESOLUTION

In the event of an identity theft or a fraud-related event, you have access to a consultation with a fraud resolution specialist who will guide you through seven emergency response activities, and provide the proper documentation and names of agencies to contact.

CHILDCARE AND EDUCATION

ComPsych's experienced professional staff gives you the knowledge, assistance, and the resources to address your unique childcare and educational needs. The EAP does the research and delivers the answers and resources you need to make informed decisions regarding your children.

ELDERCARE

If you need help with an aging parent or loved one, you have free access to supportive resources and information from your EAP. They're your resource for selecting assisted living or nursing homes, in-home care or respite resources, transportation and meal options, and more.

MEDICAL PLAN

REGENCE ADVANTAGES & DISCOUNTS

As a Regence member, taking charge of your health is easy. Regence Advantages helps you and your family save on the health-related products and services you need most. Get discounts on fitness devices, gym memberships, allergy relief and more—plus, get 20% off Walgreens brand over-the-counter health and wellness products. Regence expands their discounts and offers all the time, so be sure to check back often!

HOW IT WORKS:

Go to https://www.regence.com/member/resources/advantages-discounts and click on the various links.

MEDICAL PLAN

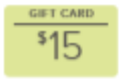
REGENCE EMPOWER WELLNESS PROGRAM

For those enrolled in the medical, Regence Empower Wellness program offers a personalized well-being experience that is guided step by step, so that you will always know what to do to meet your goals. You can earn rewards as you complete activities that help you feel your best.

You can earn up to $100 per year in gift cards for completing wellness activities during each calendar year. As a reminder, your Regence medical plans cover preventive care at no cost to you when you see an in-network provider.

HOW IT WORKS:

Go to www.regence.com , either create your account or sign in, scroll down and select “Go to Regence Empower”.



Health Assessment
Receive a personalized report with recommendations. Earn $15.

Preventive wellness exam*
Visit your doctor for preventive care checkup. Earn $25.

Breast cancer & cervical cancer screenings*
These screenings can help catch cancer sooner. Get a mammogram (ages 40+ or high risk) or a cervical cancer screening (ages 21+). Earn $25 each or $50 total.

Colorectal cancer screening*
If you're over the age of 45, talk to your provider about this screening. Sign in to Regence Empower to learn more.

Steps challenge
Get more movement and earn up to $25 per year.

Fitness device or app sync
Make every step count. Sync your fitness device or app to track your physical activity. Earn $5.

Healthy activities
Complete up to five healthy activities, including a vision exam, dental visit, select immunizations, or programs on behavioral health and insurance basics. Earn $10 for each activity.

*Activity is tracked through claims and is subject to network availability and eligibility by age and medical risk. Please allow up to 60 days for claims processing.

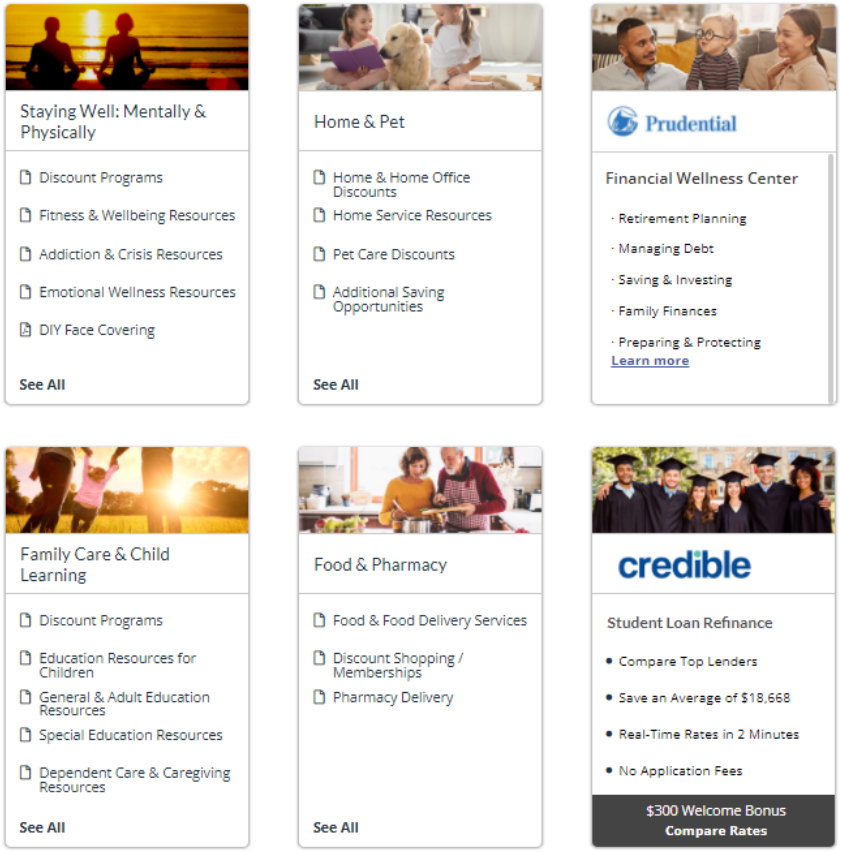
BROWN & BROWN - ADDITIONAL BENEFITS

Brown & Brown is a national insurance broker and is able to offer several additional benefits to the employees (and family members) of **Pacific Facility Solutions**. These are available regardless of whether you are enrolled in the medical/dental/vision coverage or whether you are part or full time.

BENEFITS HUB / RELIEF CENTER

Brown & Brown created a centralized "relief center" for all of our clients in hopes of offering a free resources that can help you find savings on everyday items that you need as you navigate through these challenging times. The Relief Center includes discount programs, tools, and various web resources covering a wide range of topics.

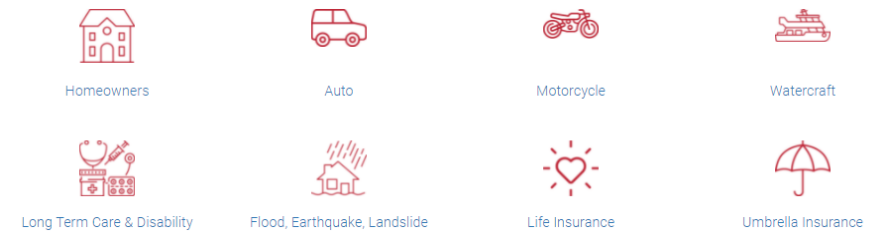
To access the relief center, please visit https://bbinsrelief.benefithub.com



PERSONAL INSURANCE NEEDS

Brown & Brown of Seattle offers expertise in your personal insurance needs, including home, auto, life, disability, long term care, and umbrella (among others). We understand that the most important part of your insurance program is making sure your family, home, lifestyle, and future are protected when the unexpected becomes reality. Our team is ready to assist with your personal insurance needs. If you are interested in having your coverages reviewed, please contact:

Matt McCoy
matt.mccoy@bbrown.com
206-216-4129



EMPLOYEE COSTS & CONTRIBUTIONS

The **Pacific Facility Solutions** Benefits Plan is designed under "Section 125" of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical, dental, and vision will be made with pre-tax dollars.

You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified "change in status." You may waive participation in the Section 125 Plan and elect to pay all contributions with after-tax dollars. Contact Human Resources for a waiver form if you elect to pay for your benefits with after-tax dollars.

Medical & Vision Plans Costs—**24** Pay Periods			
COVERAGE LEVEL	**REGENCE BLUESHIELD BASE COPAY PLAN CLASSIC 3000**	**REGENCE BLUESHIELD HSA PLAN HSA 3.0 2500 PLAN**	**REGENCE BLUESHIELD BUY UP COPAY PLAN CLASSIC 1500 PLAN**
Employee Only	$71.15	$71.15	$108.05
Employee & Spouse	$417.25	$396.83	$499.00
Employee & Child(ren)	$337.10	$320.58	$408.45
Employee & Family	$683.20	$649.83	$799.45

Voluntary Dental Plans Costs —**24** Pay Periods	
COVERAGE LEVEL	**RELIANCE STANDARD VOLUNTARY DENTAL**
Employee Only	$23.03
Employee & Spouse	$46.06
Employee & Child(ren)	$54.49
Employee & Family	$77.52

QUESTIONS

Because the world of healthcare and insurance can be confusing and hard to navigate, we are pleased to introduce your **Account Management Team** at Brown & Brown who will be able to assist you with all things related to your benefits. Your Account Management Team will be working in conjunction with the Human Resources Department to answer your questions and assist with any issues.

Matt McCoy
Account Executive
(206) 216-4129
matt.mccoy@bbrown.com

Stephen Couldry
Broker
(253) 342-2012
stephen.couldry@bbrown.com

Marin Schy
Human Resources
(360) 684-3812 x 102
marin.s@pacificfs.net

Brown & Brown Office Hours: Monday through Friday, 8:00 am to 5:00 pm PST

Plan	Carrier	Phone	Website
Medical	Regence BlueShield	888-367-2112	www.regence.com
Dental	Reliance Standard	800-497-7044	www.reliancematrix.com
Vision	Regence BlueShield VSP (Provider Network)	Customer Service—888-367-2112 Provider Network—800-877-7195	www.regence.com Provider Lookup - www.vsp.com
Regence Employee Assistance Program	Regence via ComPsych	Customer Service: 800-922-2687	www.guideanceresources.com Web ID: EAPW

NOTICES

This benefits enrollment guide is designed to provide basic information regarding benefit plans and programs available to eligible employees of Pacific Facility Solutions. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee of Pacific Facility Solutions, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Pacific Facility Solutions reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

The Pacific Facility Solutions Benefits Plan is designed under "Section 125" of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical and dental plans will be made with pre-tax dollars. You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified "change in status." You may waive participation in the Section 125 Plan and elect to pay all contributions with after-tax dollars. Contact Human Resources for a waiver form if you elect to pay for your benefits with after-tax dollars.