EMPLOYEE BENEFIT SUMMARY

PREPARED FOR THE EMPLOYEES OF

And its subsidiary;

Employee Manual

EFFECTIVE:
Medical: January 1, 2018
Dental: January 1, 2018
Vision: January 1, 2018
Life/AD&D: January 1, 2016
Long Term Disability: December 1, 2011

Presented by:
Tom Foster
Benefit Design Services, LLC
4620 200th St SW, Suite H
Lynnwood, WA 98036
Phone: (425) 712-8244
Fax: (425) 712-0541

TO: ALL BENEFIT ELIGIBLE EMPLOYEES OF YOUR MAN FRIDAY

Welcome to the annual employee benefits anniversary of our group insurance program. Please use this manual for your reference for our Medical, Dental, Vision and Life & AD&D policies. We are happy to announce that Benefit Design Services will continue to be our insurance broker. If you have any questions regarding our insurance plans they would be happy to assist you.

*If you have **not** received your ID card(s), we recommend that you contact the carrier to confirm your coverage is in effect.

CARRIER CONTACTS:

BENEFIT DESIGN SERVICES

Customer Service	(425) 712-8244
	customerservice@benefitdesign.net

Or if you wish to contact the Insurance Carrier direct please call:

MEDICAL:

- **Kaiser Permanente Access** — **Group#: 8302900**

Web Address	www.ghc.org
Customer Service	(888) 901-4636
Web Address	www.fchn.com
Customer Service	(800) 467-5281
Out of State - Web Address	www.firsthealth.com
Customer Service	(800) 226-5116

DENTAL:

- **Kaiser / DDW** — **Group#: 09152-11190**

Web Address	www.deltadentalwa.com
Customer Service	(800) 554-1907

VISION:

- **VSP** — **Group #: 30080357**, **Employee# SSN**

Web Address	www.vsp.com
Customer Service	(800) 877-7195

LIFE & AD&D or LTD or STD:

- **Hartford** — **Group#: 877759**

Web Address	www.thehartford.com
Customer Service	(800) 523-2233

- **Standard** — **Group#: 00-154051-001**

Web Address	www.standard.com
Customer Service	(800) 848-5132

Benefit Summary

Access PPO VisitsPlus Silver

KAISER PERMANENTE®

Effective Date 1/1/2018	**Health Plan** Access PPO	**Ref** C43361

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Annual deductible and plan coinsurance do not apply to office visits, but do apply to all other outpatient services, including surgical services and outpatient hospital and ambulatory surgical centers	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $7,350 Family out-of-pocket limit: $14,700 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $22,050 Family out-of-pocket limit: $44,100 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty, deductible and coinsurance do not apply. Enhanced benefit applies when services are provided by an Enhanced provider.	Deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred generic & brand/specialty $25/$55/50%/50% Preferred generic and preferred brand drugs $20/$50 enhanced. Up to a 30 day supply.	Not covered
Prescription mail order	Preferred generic/preferred brand/non-preferred generic & brand/specialty $20/$50/50%/50% up to a 90 day supply. Specialty up to a 30 day supply.	Not covered
Acupuncture	Covered up to 12 visits per calendar year without prior authorization $25 copay enhanced benefit primary/$45 copay enhanced benefit specialty	Visit limits shared with preferred provider network Deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply,
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty	Deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	130 visits per calendar year, deductible and coinsurance apply.	Visit limit shared with preferred provider network Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $25 copay enhanced benefit primary/$45 copay enhanced benefit specialty	Visit limits shared with preferred provider network Deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty. Routine care is covered in full.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay ($25 copay enhanced benefit) primary/specialty	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply
Naturopathy	$35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty	Deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay enhanced benefit primary/$45 copay enhanced benefit specialty	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply

Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 25 visits per calendar year. Services with mental health diagnoses are covered with no limit. $55 copay ($45 copay enhanced benefit) specialty	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network Deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay enhanced benefit primary/$45 copay enhanced benefit specialty Women's sterilization procedures are covered in full.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty	**Inpatient:** Deductible and coinsurance apply **Outpatient:** Deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 exam per calendar year)	**Pediatric (to age 19):** Covered in full **Adult (age 19 and over):** $35 copay ($25 copay enhanced benefit) primary/$55 copay ($45 copay enhanced benefit) specialty, deductible and coinsurance do not apply.	**Pediatric (to age 19):** Deductible and coinsurance apply **Adult (age 19 and over):** Deductible and coinsurance applies
Optical hardware Lenses, including contact lenses and frames	**Pediatric (to age 19):** Covered in full. Limited to 1 set of frames and lenses or contact lenses in lieu of eyeglasses per calendar year **Adult (age 19 and over):** $100 allowance per calendar year, deductible and coinsurance do not apply	Shared with preferred provider

KAISER PERMANENTE®

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Kaiser Foundation Health Plan of Washington Options, Inc.: Access PPO VisitsPlus Silver

Coverage Period: 1/1/2018 – 1/1/2019
Coverage for: Group | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.kp.org/wa or by calling 1-888-901-4636. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-901-4636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 individual/$5,000 family for preferred provider network $5,000 individual/$10,000 family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Does not apply to preferred provider preventive care, preferred provider prescription drugs, hospice, Children's eye exams and glasses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes, for preferred provider network $7,350 individual/$14,700 family $22,050 individual/$44,100 family out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org/wa or call 1-888-901-4636 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment ($25 copayment enhanced benefit)/visit Deductible does not apply	50% coinsurance	Manipulative therapy is limited to 10 visits per calendar year, subject to the enhanced benefit. Acupuncture is limited to 12 visits per calendar year, subject to the enhanced benefit (limits are shared with preferred and out-of-network provider networks). Enhanced benefit applies when services are provided by an Enhanced provider.
	Specialist visit	$55 copayment ($45 copayment enhanced benefit)/visit Deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	50% coinsurance	Services must be in accordance with the Kaiser Permanente well-care schedule. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	High end radiology imaging services such as CT, MRI and PET require preauthorization or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa.	Preferred generic drugs	$25 or ($20 enhanced) copayment/prescription Deductible does not apply	Not covered	Covers up to a 30-day supply Covers up to a 90-day supply at enhanced pharmacy
	Preferred brand drugs	$55 or ($50 enhanced) copayment/prescription Deductible does not apply	Not covered	Covers up to a 30-day supply Covers up to a 90-day supply at enhanced pharmacy
	Non-preferred generic/brand drugs	50% coinsurance Deductible does not apply	Not covered	Covers up to a 30-day supply
	Specialty drugs	50% coinsurance Deductible does not apply	Not covered	Covers up to a 30-day supply
	Mail-order drugs	Preferred generic $20 copayment, Preferred brand $50 copayment, non-preferred generic/brand 50% coinsurance, specialty 50% coinsurance Deductible does not apply	Not covered	Covers up to a 90-day supply Specialty drugs covered up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible.
	Emergency medical transportation	30% coinsurance	50% coinsurance	None
	Urgent care	$35 copayment ($25 copayment enhanced benefit)/visit primary/$55 copayment ($45 copayment enhanced benefit)/visit specialty	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.

* For more information about limitations and exceptions, see the plan or policy document at www.kp.org/wa.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment ($25 copayment enhanced benefit)/visit primary/$55 copayment ($45 copayment enhanced benefit)/visit specialty	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.
If you are pregnant	Office visits	$35 copayment ($25 copayment enhanced benefit)/visit primary/$35 copayment ($25 copayment enhanced benefit)/visit specialty	50% coinsurance	Preventive services related to prenatal and preconception care is covered as preventive care. Routine care is covered as preventive care and not subject to the copayment.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Newborn services cost shares are separate from that of the mother.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 130 visits per calendar year Requires preauthorization or will not be covered.
	Rehabilitation services	$55 copayment ($45 copayment enhanced benefit)/visit for outpatient 30% coinsurance for inpatient	50% coinsurance for outpatient 50% coinsurance for inpatient	Limited to 25 visits per calendar year/outpatient. Limited to 30 days per calendar year/inpatient. Services with mental health diagnoses are covered with no limit. Limits are combined with preferred and out-of-network provider networks.
	Habilitation services	$55 copayment ($45 copayment enhanced	50% coinsurance for outpatient	Limited to 25 visits per calendar year/outpatient. Limited to 30 days per

* For more information about limitations and exceptions, see the plan or policy document at www.kp.org/wa.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		benefit)/visit for outpatient 30% coinsurance for inpatient	50% coinsurance for inpatient	calendar year/inpatient. Services with mental health diagnoses are covered with no limit. Limits are combined with preferred and out-of-network provider networks.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Limits are combined with preferred and out-of-network provider networks. Requires preauthorization or will not be covered.
	Durable medical equipment	30% coinsurance	50% coinsurance	Requires preauthorization or will not be covered.
	Hospice services	No charge Deductible does not apply	50% coinsurance	Requires preauthorization or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	50% coinsurance Deductible does not apply	Limited to one exam every 12 months. Limits are combined with preferred and out-of-network provider networks.
	Children's glasses	No charge Deductible does not apply	No charge Deductible does not apply	Limited to 1 pair of frames and lenses or contact lenses per year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs
	• Non-emergency care when traveling outside the U.S.	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: : The Washington Office of Insurance Commissioner at : http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: http://www.insurance.wa.gov/your-insurance/email-us/. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.kp.org/wa.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other (blood work) coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$40
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,400

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other (blood work) coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$1,800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3,090

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other (blood work) coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.

DELTA DENTAL® | KAISER PERMANENTE®

Small Group

2018 Adult and pediatric dental coverage

As a Kaiser Permanente member, you have access to dental coverage through Delta Dental of Washington. The Standard plan includes adult coverage for members and their dependents aged 19 or older, and mandated pediatric coverage for members or their dependents through age 18.

Please review this summary of benefits to get familiar with the Standard plan, and refer to your Delta Dental benefits booklet for full details.

Summary of Benefits	**Standard**			
	Pediatric		**Adult**	
	Delta Dental participating dentist	**Non-participating dentist**	**Delta Dental participating dentist**	**Non-participating dentist**
Annual maximum	Unlimited		$1,500 $1,000 annual TMJ[1] maximum $5,000 lifetime TMJ[1] maximum	
Annual deductible Waived on Class I benefits	$50 / child		$50 / adult	
Annual out-of-pocket maximum	$350 / child $700 / family	Not applicable	Not applicable	
Diagnostic and preventive Exams, prophylaxis, fluoride, X-rays, sealants	100%	100%	100%	100%
Restorative Restorations (includes posterior composites[2]), endodontics, periodontics, oral surgery[3]	80%	80%	80%	80%
Major Crowns,[3] dentures, partials, bridges, implants and TMJ for adults over age 19	50%	50%	50%	50%
Orthodontia Coinsurance Lifetime maximum	Medically necessary[3] 50% Unlimited		50% $1,000	

Delta Dental provider network includes both the Delta Dental PPO℠ and Delta Dental Premier® networks
$700 per family maximum out-of-pocket limit only applies to members up to age 19.
Composite fillings on posterior teeth are paid at amalgam level for members 19+
Composite fillings on posterior teeth are covered for member under age 19.

1. TMJ = Temporomandibular joint
2. Covered for members under 19
3. Requires preauthorization

continued next page

Finding a participating dentist

This plan allows you to choose dentists from two networks: Delta Dental PPO or Delta Dental Premier. You can find a participating, in-network dentist in your area by visiting deltadentalwa.com and using the Find a Dentist tool.

The advantages of seeing a Delta Dental PPO or Delta Dental Premier dentist

We encourage you to see a Delta Dental of Washington network dentist because they provide treatments at discounted rates and file all claim paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance, or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of-pocket savings if you choose a dentist from the Delta Dental PPO network.

About using in-network and out-of-network dentists

When visiting an in-network dentist, be sure to mention that you're covered by Delta Dental of Washington and give them your member identification number, plan name, and group number.

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible for having the dentist complete your claim forms and to ensure that the claims are submitted to Delta Dental. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after Delta Dental pays. Unlike participating dentists, Delta Dental has no control over non-participating dentists' charges or billing procedures.

Questions?

Call Delta Dental of Washington at 1-800-554-1907, Monday to Friday, 8 a.m. to 5 p.m. or go online to deltadentalwa.com for answers.

Your Vision Benefits Summary

Vision care for life

Get access to the best in eye care and eyewear with YOUR MAN FRIDAY, INC. and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—choose a VSP network doctor or any out-of-network provider. Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2018
VSP Provider Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 12 months	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam	up to $50	Lined Trifocal Lenses	up to $100
Frame	up to $70	Progressive Lenses	up to $75
Single Vision Lenses	up to $50	Contacts	up to $105
Lined Bifocal Lenses	up to $75		

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.