EMPLOYEE BENEFITS SUMMARY

March 1, 2023—February 28, 2024

Omni
STAFFING SERVICES

*Prepared exclusively for employees of Omni Staffing Service by Desert Insurance Benefits, Inc.

Desert Insurance Benefits Inc.

Current Insurance Carriers:

Medical Insurance: Asuris Northwest Health

Dental Insurance: Principal Financial Group

Vision Benefits: Vision Service Plan

Insurance Broker : Desert Insurance Benefits

Contact Info:

Asuris Northwest Health

Customer Service: 1-888-367-2109

Website: www.asuris.com

Principal Financial Group

Customer Service: 1-800-986-3343

Website: http://www.principal.com

Vision Service Plan

Customer Service: 1-800-295-9058

Website: www.vsp.com

Desert Insurance Benefits

Customer Service: 1-509-765-5632

email: will@desertins.net

.A copy of the Federally Required SBC (Summary of Benefits and Coverage) is included in this booklet.

A paper copy of the benefits policy plan can be obtained upon request from Desert Insurance Benefits

EMPLOYEE CONTRIBUTIONS

Medical

Your per-month Employee Contribution to your Medical Plans is:

Employee Only	$134.53
Employee + Spouse	$812.21
Employee + Children	$625.44
Employee + Spouse + Children	$1303.06

* Employee Costs can be pre-tax. The net costs will be less.

Voluntary Dental

Your per-month Employee Contribution to your Dental Plans is:

Employee Only	$50.88
Employee + Spouse	$102.84
Employee + Children	$105.78
Employee + Spouse + Children	$164.34

* Employee Costs can be pre-tax. The net costs will be less.

Voluntary Vision

Your per-month Employee Contribution to your Vision plan is:

Employee Only	$10.85
Employee + Spouse	$15.73
Employee + Children	$15.73
Employee + Spouse + Children	$28.21

* Employee Costs can be pre-tax. The net costs will be less.

Medical Plan Summary

Carrier	AIMS(1/1) - Asuris NW	
Plan Name	PPO Traverse $3000/20%/$35	
Plan Network	PREFERRED	
HSA Qualified	No	
Effective Date	03/01/2023	
End Date	1/01/24	
	IN-NETWORK	**OUT-OF-NETWORK**
DEDUCTIBLE	Individual: $3,000	Combined with in-network
	Family: $6,000	Combined with in-network
OUT OF POCKET	Individual: $7,500	Combined with in-network
	Family: $15,000	Combined with in-network
	Includes: Deductible, copays ($), coinsurance (%), Rx	Deductible, copays ($), coinsurance (%), Rx
OFFICE VISITS	Covered Before Deductible: All visits	PAR: All visits | OON: None
	Preventive Care: Covered in full	PAR: Covered in full | OON: Deductible, then 40%
	Primary Care: $35	PAR: $35 | OON: Deductible, then 40%
	Specialist: $50	PAR: $50 | OON: Deductible, then 40%
ON DEMAND CARE	Telehealth: MD Live: Covered in full	Not covered
	Urgent Care: As any other office visit	As any other office visit
	Emergency Room: $300 copay, then deductible, then 20%	$300 copay, then deductible, then 20%
HOSPITAL	In-patient: Deductible, then 20%	Deductible, then 40%
LAB & X-RAY	Diagnostic Non-complex: 1st $500 covered in full. Then deductible, then 20%.	1st $500 covered in full. Then deductible, then 40%.
	Diagnostic Complex: See NonComplex lab/X-ray	See NonComplex lab/X-ray
PHYSICAL THERAPY & ALTERNATIVE CARE	Acupuncture (A): Deductible, then 20%	Deductible, then 40%
	Chiropractic (C): Deductible, then 20%	Deductible, then 40%
	Physical Therapy (PT): Deductible, then 20%	Deductible, then 40%
	Massage (M): Deductible, then 20%	Deductible, then 40%
	Maximum Visits A/C/PT/M: 12 | 18 | 25 | included under PT	Varies - See booklet
COUNSELING	Mental Health: $35	PAR: $35 | OON: Deductible, then 40%
	Chemical Dependency: $35	PAR: $35 | OON: Deductible, then 40%
PRESCRIBED DRUGS	Deductible: None	None
	Out of Pocket Max: Included under medical	Included under medical
	Retail: Tier 1: $10 Tier 2: $40 Tier 3: $60	$10 $40 $60
	Mail Order: T1:$20 | T2:$80 | T3:$120	T1:$20 | T2:$80 | T3:$120
	Specialty: 50%, 1st fill retail then mail only, 30 day supply	50%, 1st fill retail then mail only, 30 day supply
PEDIATRIC BENEFITS	Vision: Not covered	Not covered
	Dental: Not covered	Not covered

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Asuris Northwest Health: Traverse 3000

Coverage Period: 01/01/2023 – 12/31/2023
Coverage for: Individual and Eligible Family | **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 https://asuris.com or call 1 (888) 370-6162 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 healthcare.gov/sbc-glossary or call 1 (888) 370-6162 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 individual / $6,000 family per calendar year.	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?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	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 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?	$7,500 individual / $15,000 family per calendar year.	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-billing 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 https://asuris.com/go/EW/Preferred or call 1 (888) 370-6162 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a nonparticipating 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 a nonparticipating 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 pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay / office visit, deductible does not apply; 20% coinsurance for all other services	$35 copay / office visit, deductible does not apply; 40% coinsurance for all other services	40% coinsurance	Copayment applies to each preferred or participating office visit only. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$50 copay / office visit, deductible does not apply; 20% coinsurance for all other services	$50 copay / office visit, deductible does not apply; 40% coinsurance for all other services	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $500 / year, then 20% coinsurance for outpatient services; 20% coinsurance for inpatient services	No charge for the first $500 / year, then 40% coinsurance for outpatient services; 40% coinsurance for inpatient services	No charge for the first $500 / year, then 40% coinsurance for outpatient services; 40% coinsurance for inpatient services	Once outpatient diagnostic tests and imaging combined reach $500 / year, services are covered at the coinsurance specified, after deductible.
	Imaging (CT/PET scans, MRIs)	No charge for the first $500 / year, then 20% coinsurance for outpatient services; 20% coinsurance for inpatient services	No charge for the first $500 / year, then 40% coinsurance for outpatient services; 40% coinsurance for inpatient services	No charge for the first $500 / year, then 40% coinsurance for outpatient services; 40% coinsurance for inpatient services	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://asuris.com/go/2023/EW/4tier	Tier 1	$10 copay / retail prescription $20 copay / home delivery prescription			Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / home delivery (mail order) prescription 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery (mail order). Coverage includes compound medications at 50% coinsurance. Cost shares for insulin will not exceed $35 / 30-day supply retail prescription or $105 / 90-day supply home delivery (mail order) prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy, or for self-administrable cancer chemotherapy drugs. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 2	$40 copay / retail prescription $80 copay / home delivery prescription			
	Tier 3	$60 copay / retail prescription $120 copay / home delivery prescription			
	Tier 4	50% coinsurance / specialty drugs			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	40% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $300 copay / visit	20% coinsurance after $300 copay / visit	20% coinsurance after $300 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay / office visit, deductible does not apply; 20% coinsurance for all other services	$35 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Copayment applies to each preferred and participating office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	25 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	60 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6162 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 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 plan at 1 (888) 370-6162 or visit asuris.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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) 370-6162

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	**$3,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$11
Coinsurance	$1,743
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$4,815**

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$790
Copayments	$894
Coinsurance	$0
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,862**

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,677
Copayments	$455
Coinsurance	$73
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,205**

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

Telehealth powered by Doctor On Demand

Use telehealth for 24/7 care

Doctor On Demand™ gives you access to great medical care anytime, day or night

Skip the wait and see a doctor or therapist online

We all have times when we need to see a doctor, but it's inconvenient—there's no time, the office is closed, or we're on the road. You know that feeling: "I wish I could get care without the leaving the house!" Now you can.

Your health plan includes telehealth powered by Doctor On Demand, a national leader in quality care. You can talk to any of Doctor On Demand's board-certified physicians any time by video chat using your computer or the app—24 hours a day, 7 days a week, 365 days a year.

ASURIS NORTHWEST HEALTH

Telehealth powered by Doctor On Demand

Use telehealth for 24/7 care

Quality care from doctors you can trust

You'll connect with board-certified doctors and therapists who can diagnose and treat non-emergency medical conditions, prescribe medications, and send prescriptions to your pharmacy. With specialties including primary care, pediatrics, and family medicine, Doctor On Demand makes it easy to get quality care for every member of your family.

Common ailments treated via telehealth include:

Addictions	Ear infections	Rashes	Sunburn
Allergies	Headache	Relationship issues	Trauma & loss
Cold & flu	Infections	Sinus infection	Workplace stress
Constipation	Nausea	Social anxiety	And more
Depression	Pink eye	Sore throat	

How it works

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 three minutes.
- You can use Doctor On Demand as often as you need to.
- We process each visit as a claim, and your costs count toward your deductible.
- Check your specific benefits for cost information. You won't pay more than $49 for a medical visit.
- This is more than a nurse advice line. With Doctor On Demand, a doctor can diagnose, treat and prescribe medications.
- You will work with a Doctor On Demand physician, not your regular doctor.
- With your permission, the Doctor On Demand physician will share your treatment information with your regular doctor.
- Visit **doctorondemand.com/asuris** to register today. You'll want to create your online account in advance so when you need care, you'll already be set up.

ASURIS NORTHWEST HEALTH

528 E Spokane Falls Blvd., Suite 301
Spokane, WA 99202

ANH-199655-18

Preventive care

In-network services covered at 100%

Most Asuris members have 100% coverage for preventive services—care that detects an issue before it becomes a problem. You'll pay nothing for the care listed here when you see an in-network provider. We follow recommendations from three government agencies to determine which services we cover.[1]

You may have to pay for covered preventive care if:

- You see an out-of-network provider
- Your doctor provides preventive care outside the guidelines
- Your provider doesn't obtain any required pre-authorization (for example, physical therapy for fall prevention, genetic testing for BRCA 1 and 2 and lung cancer screening)

Also, diagnostic services are different from preventive. Diagnostic care looks at a problem you're already having. So ask your doctor if services are preventive or diagnostic. It's important to know because you may have to pay out of pocket for diagnostic care.

Check the list below to see which preventive services most of our plans cover. Some plans may have limitations or not cover all of these services. Check your plan benefits or call Customer Service at the number on the back of your member ID card if you have questions.

1. These scientifically supported guidelines are created by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA).[1]

ASURIS NORTHWEST HEALTH

Principal®

Policyholder: OMNI STAFFING SERVICES

Group dental insurance
Benefit summary for
all members

Your coverage renews every April 1
This summary was created on 02/02/2023 and shows benefits available at that time.

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	90%	80%
Major	$50	$50	60%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your deductibles that are in and out-of-network for basic and major services are combined.			
Combined maximum	Maximums for basic and major procedures are combined. In-network calendar year maximums are $3,000 per person or non-network calendar year maximums are $3,000 per person.			
Preventive passport	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

DENTAL BENEFITS

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Four per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Twice per calendar year (covered only for dependent children under age 14)
Sealants	Covered only for dependent children under age 14; once per tooth each 24 months
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit

Basic	
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Occlusal guards (night guards)	One guard per 36 months
Harmful habit appliance	Covered only for dependent children under age 14

Major	
Crowns	Each 84 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 84 months per tooth
Implants	Each 84 months per tooth
Bridges	84 months old (initial placement / replacement)

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Preventive passport	Benefits paid for preventive services will not be applied to your annual benefit maximum
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

VISION BENEFITS

Your VSP Vision Benefits Summary

OMNI STAFFING SERVICES and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature

EFFECTIVE DATE:
03/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME*	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Progressive lenses • Anti-glare coating • Tints/Light-reactive lenses • Scratch-resistant coating • Average savings of 40% on other lens enhancements	$0 $0 $0 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** 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.		
	Routine 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 GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.

A Look at Your VSP Vision Coverage

With VSP and OMNI STAFFING SERVICES, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON. · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

FREQUENTLY ASKED QUESTIONS

What if I have other coverage?

If you have other coverage you should notify your plan administrator or Desert Insurance so that you can complete an "other coverage questionnaire" and the coverage's will coordinate benefits. Other coverage may include Medicare, other group health coverage, or individual coverage.

Once I am insured what am I responsible for?

Generally there are three ways that you participate in medical costs.

1. *Co-Pays: for specific circumstances (office visits, emergency room, pharmacy)*
2. *Deductible: this is your responsibility before the insurer participates.*
3. *Co-Insurance: once the deductible has been met; most insurers pay 80% of the cost if services are rendered in network. You would be responsible for the balance generally up to a specific out of pocket limit*

What is an Explanation of Benefits or an E.O.B.?

This is the statement that you receive from your insurer once a claim has been acted on. We refer to them as E.O.B.'s. They will tell you how the claim was processed and what responsibility is yours.

When can I add or change dependents from the plans?

*Dependents can be removed at any time. Dependents can only be added during open enrollment which is **March 1st** or after a qualifying event. A qualifying event may include: loss of other coverage, birth, divorce, marriage etc…*

How can I replace a lost ID card?

*A lost ID card can be replaced by **calling Asuris or Desert Insurance Benefits Inc***

Desert INSURANCE BENEFITS INC.

Lindy Russell, CLU
Brooks Russell
Will Christensen

Desert Insurance Benefits, Inc.
A: 1006 W. Ivy St. Moses Lake, WA 98837
P: (509) 765-5632
E: info@desertins.net
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