HEALTH INSURANCE RATES: 3-1-2022 - 2-28-2023 Premera Blue Cross

Adult Rate: $473.20
Child Rate (0-20): $242.04

DENTAL INSURANCE RATES: 4-1-2022 - 3-31-2023 Principal Dental

Employee Only Rate: $50.88
Employee + Spouse: $102.84
Employee + Child(ren): $105.78
Employee + Family: $164.34

VISION INSURANCE RATES: 3-1-2020 - 2-28-2022 VSP - Vision Service Plan

Employee Only Rate: $10.85
Employee + 1: $15.73
Employee + 2 or more: $28.21

Employee Cost: Basic Breakdown

Health Insurance - Premera Choice 2500 Silver				
Deductible $2500				
Total Cost (Monthly)	**Employer Portion (Monthly)**	**Employee Portion (Monthly)**	**+Spouse (Monthly)**	**+Child (0-20 years old) (Monthly)**
$473.20	$354.90	$118.30	+$473.20	+$242.04

Vision Insurance - VSP Voluntary - Paid by Employee in Full				
Total Cost (Monthly)	**Employer Portion (Monthly)**	**Employee Portion (Monthly)**	**Employee +1 (Monthly)**	**Employee +2 or more (Monthly)**
$10.85	$0	$10.85	$15.73	$28.21

Dental Insurance - Principal Voluntary - Paid by Employee in Full					
Max $3000/Calendar Year					
Total Cost (Monthly)	**Employer Portion (Monthly)**	**Employee Portion (Monthly)**	**+Spouse (Monthly)**	**+Child(ren) (0-20 yrs old) (Monthly)**	**Employee + Family**
$50.88	$0	$50.88	$102.84	$105.78	$164.34

Employee Portion	Medical	Dental	Vision	Total (All 3)
Per Month	$118.30	$50.88	$10.85	$180.03
Per Week	$27.30	$11.74	$2.51	$41.55

Employee Portions +Spouse				
Employee Portion	**Medical**	**Dental**	**Vision**	**Total (All 3)**
Per Month	$591.50	$101.76	$15.73	$708.99
Per Week	$136.50	$23.48	$3.63	$163.61

Employee Portions +Child				
Employee Portion	**Medical**	**Dental**	**Vision**	**Total (All 3)**
Per Month	$360.34	$105.78	$15.73	$481.85
Per Week	$83.16	$24.41	$3.63	$111.20

PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Effective Date: 01/01/2021

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**CHOICE 2500 SILVER**	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (In-network only - Family embedded deductible 2X Individual)	$2,500	$5,000
Coinsurance	30%	50%
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$8,150	Unlimited
Office Visit Cost Share	$35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit (Includes Telemedicine)	$35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Virtual Care (Designated Provider)	$5 Copay, applies to the $8,150 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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MEDICAL PLAN	CHOICE 2500 SILVER	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Outpatient Professional Services	$2,500 Deductible, then 30% Coinsurance, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
2 Emergency and Transportation Services		
Emergency Room - facility	$250 Copay then $2,500 Deductible and 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum	$250 Copay then $2,500 Deductible and 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum
Ambulance Service - ground (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum
Ambulance Service - air (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$2,500 Deductible, then 30% Coinsurance, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum
Organ Transplants (Unlimited; $5,000 travel and lodging limits)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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MEDICAL PLAN	CHOICE 2500 SILVER	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Mental Health Office Visit (Unlimited)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
6 Prescription Drug		
Drug List	M4 Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred generic and brand Tier 4 = specialty	Not Covered
Retail (preferred generic/preferred brand/non-preferred) (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	Waive Deductible, then $30/ Waive Deductible, then $70/$2,500 Deductible, then 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum	Not Covered
Mail Order (preferred generic/preferred brand/non-preferred) (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	Waive Deductible, then $90/ Waive Deductible, then $210/$2,500 Deductible, then 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum	Not Covered
Specialty Rx (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	$2,500 Deductible, then 30% Coinsurance, applies to the $8,150 Out of Pocket Maximum	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Habilitation Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Massage Therapy (Applies to rehab)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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MEDICAL PLAN	CHOICE 2500 SILVER	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
8 Laboratory/Imaging Services		
Pathology	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Imaging - basic	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Imaging - major (MRI, CT, PET)	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	$2,500 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
9 Preventive/Wellness Services & Chronic Disease Management		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
Preventive Laboratory Screens	Covered In Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Imaging	Covered In Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Routine Mammography	Covered In Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY Under age 19)	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered In Full	Covered In Full
Pediatric Dental (preventive)	Covered In Full	Medical $5,000 Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental (basic)	Waive Medical Deductible, then 20% Coinsurance, applies to $8,150 Out of Pocket Maximum	Medical $5,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental (major)	Medical $2,500 Deductible, then 50% Coinsurance, applies to $8,150 Out of Pocket Maximum	Medical $5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Routine Hearing		

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MEDICAL PLAN	CHOICE 2500 SILVER	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Routine Hearing Exam (1 every 2 calendar years)	$65 Copay	$65 Copay
Routine Hearing Aids and Hardware ($1000 every 3 calendar years)	Covered In Full	Covered In Full
Alternative Care		
Chiropractic (10 visits PCY)	$35 Copay, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	$35 Copay, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopath (Unlimited)	$35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $65 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Premera Designated Centers of Excellence		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Designated Provider: Covered in Full; Non-Designated Provider: Not Covered	Not Covered
Travel and Care Coordination (Limited to IRS Guidelines)	Covered In Full	Not Covered

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ເສັຽຄ່າ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

A LOOK AT YOUR VSP VISION COVERAGE

VSP Vision care for life

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM OMNI STAFFING SERVICES AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

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 for additional savings.

PROVIDER CHOICES YOU WANT.
With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 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®—a comprehensive exam designed to detect eye and health conditions.

PROVIDER NETWORK:
VSP Signature

EFFECTIVE DATE:
03/01/2021

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	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • Every 12 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• Progressive lenses • Anti-glare coating • Tints/Light-reactive lenses • Scratch-resistant coating • Average savings of 40% on other lens enhancements • Every 12 months	$0 $0 $0 $0
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20 per exam
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 WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

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.

Contact us:

800.877.7195 or **vsp.com**

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Policyholder: OMNI STAFFING SERVICES

Principal®

Group dental insurance benefit summary for

all members

Effective date: 04/01/2021

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.

Combined annual benefit maximum

This is the total amount your insurance will cover annually for basic and major services combined.

Combined annual benefit maximum - basic and major	
In-network	Out-of-network
$3,000	$3,000

Preventive

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$0	$0	100%	100%

- 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 prophylaxis - if three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit

Basic

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	90%	80%

- Fillings - covered once every 24 months
- Composite (tooth colored) fillings covered on posterior teeth
- Simple oral surgery (simple extractions)
- Complex oral surgical procedures (impacted teeth)
- 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

Major

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	60%	50%

- Crowns – each 84 months per tooth
- Core buildup - each 84 months per tooth
- Implants – each 84 months per tooth
- Bridges (initial placement / replacement) - 84 months old
- Dentures (initial placement / replacement) - 60 months old

Additional benefits

- Family deductible - 3 times the per person deductible amount
- Combined deductible - Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.
- 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.

There are additional limitations to your coverage. A complete list is included in your booklet.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. 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.

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 800-832-4450, 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.

There are additional limitations to your coverage. A complete list is included in your booklet.

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This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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