
EMPLOYEE BENEFIT SUMMARY

PREPARED FOR THE EMPLOYEES OF



EFFECTIVE:
Medical: September 1, 2022
Dental: September 1, 2022
Vision: September 1, 2022
Life: September 1, 2022

Presented by:

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THIS MEMORANDUM HAS BEEN PREPARED TO HELP YOU REVIEW THE KEY FACTORS THAT ARE ASSOCIATED WITH YOUR BENEFIT PLAN. THIS MEMORANDUM DOES NOT PROVIDE ALL OF THE CONTRACTUAL PROVISIONS, LIMITATIONS OR EXCLUSIONS INCLUDED IN YOUR POLICY AND SHOULD BE CONSIDERED ONLY AS A SUMMARY OF YOUR CURRENT BENEFITS. IF ANY DIFFERENCES EXIST BETWEEN THIS SUMMARY AND THE OFFICIAL CONTRACTS, THE CONTRACTS SHALL PREVAIL.

TO: ALL BENEFIT ELIGIBLE EMPLOYEES OF FRONTIER NORTH AMERICA

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:

- **NWEM / Regence BlueShield**
Web Address
Customer Service

Group #: 10043720

www.regence.com

(888) 367-2112

DENTAL:

- **Principal**
Web Address
Customer Service

Group #: 1097598-10001

www.principal.com

(800) 986-3343

VISION:

- **NWEM / VSP**
Web Address
Customer Service

Group #: Employee# SSN

www.vsp.com

(800) 877-7195

LIFE & AD&D:

- **NMR / Companion Life**
Web Address
Customer Service

Group #: 904-1400735-000

www.companionlife.com

(800) 753-0404

- **NWEM / LifeMap**

Web Address
Customer Service

Group #: WA300625

EE# Employee SSN

www.lifemapco.com

(800) 286-1129

COBRA Administration:

- **Sound Benefit Administration**
Web Address
Customer Service

www.soundadmin.com

(360) 779-7047



Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per calendar year	\$4,000 Individual \$12,000 Family	Shared with In-Network
Annual Prescription Deductible	The total deductible you pay per calendar year for prescription medications		Not applicable
Annual Out-of-Pocket Maximum	The combined total for your deductible(s), coinsurance and copays per calendar year	\$7,150 Individual \$14,300 Family	Shared with In-Network

Be aware that your actual costs for covered services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill you for the difference between the amount charged and our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		\$35 copay per visit, deductible waived	40%
Specialist Visits		\$35 copay per visit, deductible waived	40%
Urgent Care Visits		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 (Radiology and Laboratory or Complex Imaging).	
Other Professional Services		20%	40%
Preventive Care/Immunizations		Covered in full	40%
Radiology and Laboratory - Outpatient		20%	40%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	20%	40%
Acupuncture	12 visits per calendar year	\$35 copay per visit, deductible waived	40%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment		20%
Ambulatory Surgical Center		10%	40%
Emergency Room	Facility and professional services	\$100 copay per visit, then deductible and 20% coinsurance	
Home Health Care	130 visits per calendar year	20%	40%
Hospice Care	14 days per lifetime for Respite Care only	20%	40%
Hospital Care - Inpatient		20%	40%
Hospital Care - Outpatient		20%	40%
Maternity	Routine maternity and complications due to pregnancy	20%	40%
Mental Health/Substance Use Disorder - Inpatient		20%	40%
Mental Health/Substance Use Disorder - Outpatient		\$35 copay per outpatient office/psychotherapy visit, deductible waived	40%
Neurodevelopmental Therapy	25 visits per calendar year	\$35 copay per visit, deductible waived	40%
Nutritional Counseling	3 visits per calendar year	20%	40%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Palliative Care	30 visits per calendar year	20%	40%
Rehabilitation Services - Inpatient	30 days per calendar year	20%	40%
Rehabilitation Services - Outpatient	25 visits per calendar year	\$35 copay per visit, deductible waived	40%
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	\$20 copay per visit, deductible waived	40%
Skilled Nursing Facility	60 days per calendar year	20%	40%
Spinal Manipulations	12 spinal manipulations per calendar year	\$35 copay per visit, deductible waived	40%
Virtual Care - Telehealth	Doctor visits via phone or video chat when <u>not</u> in a healthcare facility	Vendor: \$10 copay per visit, deductible waived In-Network non-Vendor Provider: \$35 copay per visit, deductible waived	40%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	20%	40%

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Generic	90-day supply for retail or mail order	\$10 retail prescription* / \$30 mail order prescription
Preferred Brand	90-day supply for retail or mail order	\$35 retail prescription* / \$105 mail order prescription
Brand	90-day supply for retail or mail order	\$75 retail prescription* / \$225 mail order prescription
Specialty	30-day supply for retail	Refer to Generic, Preferred Brand and Brand above for participating pharmacy retail prescription

*1 copay per 30 day supply

Insulin Cost Share Cap: Retail and Mail Order: \$100 cap on member cost share per 30 day supply, deductible waived; \$300 cap on member cost share up to 90 day supply, deductible waived

0% for each self-administrable Cancer Chemotherapy medication, deductible waived

More information about prescription drug coverage is available at <https://regence.com/go/2022/WW/3tier>

Frequently Asked Questions

How is my privacy protected?	Regence is committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information. You can view our full privacy practices online at regence.com .
What if I need access to specialty care? Do I need a referral?	You can receive care from any in-network provider without a referral. For some services, prior authorization may be required.

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY.** Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

1 (888) 367-2112 - TTY: 711 | 1800 Ninth Avenue, Seattle, WA 98101 | regence.com

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Regence:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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 Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/onlineServices/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 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。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínizin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ

ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማሳሰቢያ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)፡፡

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)



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://regence.com/go/2022/booklet/WW/RegenceClassic51-100> or call 1 (888) 367-2112. 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) 367-2112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,000 individual / \$12,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own <u>individual deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> <u>without cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	You don't have to meet <u>deductibles</u> for specific services.
Are there other <u>deductibles</u> for specific services?	No.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is the <u>out-of-pocket limit</u> for this plan?	\$7,150 individual / \$14,300 family per calendar year.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
What is not included in the <u>out-of-pocket limit</u>?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/WW/Preferred or call 1 (888) 367-2112 for a list of <u>network providers</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	



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
		In-Network 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 <u>copay</u> / office visit, <u>deductible</u> does not apply;	40% <u>coinsurance</u>	<u>Copayment</u> applies to each in- <u>network</u> office and retail clinic visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
		\$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply;		
		20% <u>coinsurance</u> for all other services		
	<u>Specialist</u> visit	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	
If you have a test	Preventive care/ <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network 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 <u>prescription drug coverage</u> is available at https://regence.com/go/2022MWW/3tier	Generic drugs	\$10 <u>copay</u> / retail prescription \$30 <u>copay</u> / mail order prescription		Prescription drugs not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / mail order prescription 30-day supply / <u>specialty drug</u> retail prescription Specialty drugs are not available through mail order. Coverage includes compound medications at 50% <u>coinsurance</u> , refer to your <u>plan</u> for further information. <u>Cost shares</u> for insulin will not exceed \$100 / 30-day supply retail prescription or \$300 / 90-day supply mail order prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy, or for self-administrable cancer chemotherapy drugs. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Preferred brand drugs	\$35 <u>copay</u> / retail prescription \$105 <u>copay</u> / mail order prescription		
	Brand drugs	\$75 <u>copay</u> / retail prescription \$225 <u>copay</u> / mail order prescription		
	<u>Specialty drugs</u>	Refer to generic, preferred brand and brand drugs above.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	Covered the same as If you visit a health care provider's office or clinic (Primary care visit or <u>Specialist</u> visit) or If you have a test above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	<u>Copayment</u> applies to each in-network office/psychotherapy visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
If you are pregnant	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	\$35 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u>	30 inpatient days / year 25 outpatient visits / year Copayment applies to each in-network outpatient visit only. All inpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	\$35 <u>copay</u> / professional visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	25 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
	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.)		
<ul style="list-style-type: none">Bariatric surgeryCosmetic surgery, except congenital anomaliesDental care (Adult)Hearing aids	<ul style="list-style-type: none">Infertility treatmentLong-term carePrivate-duty nursing	<ul style="list-style-type: none">Routine eye care (Adult)Routine foot care, except for diabetic patientsWeight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">AbortionAcupuncture	<ul style="list-style-type: none">Chiropractic care	<ul style="list-style-type: none">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 ccio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2112. 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) 367-2112 or visit regence.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) 367-2112.

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

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** \$4,000
- **Specialist copayment** \$35
- **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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$11
<u>Coinsurance</u>	\$1,643
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$5,715

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$4,000
- **Specialist copayment** \$35
- **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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$877
<u>Copayments</u>	\$799
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$178
The total Joe would pay is	\$1,854

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$4,000
- **Specialist copayment** \$35
- **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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,990
<u>Copayments</u>	\$350
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,340

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

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Regence:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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 Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/online services/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 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。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ

ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማሳሰቢያ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

Group dental insurance
Benefit Summary for
all members

Policy anniversary: September 1

The benefits shown below are the benefits available as of 08/02/2022.

Network	Dental Preferred Provider Organization (PPO)
Network service area	Includes the Illinois counties of Adams, Alexander, Bond, Boone, Carroll, Champaign, Clark, Clinton, Coles, Cook, Cumberland, DeKalb, DeWitt, DuPage, Edgar, Effingham, Fayette, Ford, Franklin, Fulton, Greene, Grundy, Hardin, Henderson, Henry, Iroquois, Jackson, Jefferson, Jersey, Kane, Kankakee, Kendall, Lake, LaSalle, Lee, Livingston, Logan, Macon, Macoupin, Madison, McDonough, McHenry, McLean, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Putnam, Randolph, Rock Island, St. Clair, Saline, Sangamon, Shelby, Stephenson, Tazewell, Union, Vermillion, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, Woodford.

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%	90%
Major	\$50	\$50	60%	60%
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 preventive, basic, and major procedures are combined. In-network calendar year maximums are \$2,000 per person or non-network calendar year maximums are \$2,000 per person.			
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.
 - 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.
 - 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.

Which procedures are covered, and how often?

Preventive

Routine exams	Once per six months
Routine cleanings	Once per six months
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 14)
Sealants	Covered only for dependent children under age 14; once per tooth each 36 months

Basic

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
Fillings	Replacement fillings every 24 months
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 planning	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Harmful habit appliance	Covered only for dependent children under age 14

Major	
Crowns	Each 120 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 120 months per tooth
Implants	Each 120 months per tooth
Bridges	120 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90 th percentile of the usual and customary charges.
Emergency services	If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider. You must provide information either with the claim or during an appeal that identifies the situation as an emergency.
Participating provider services	If you require treatment and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider. You must provide information either with the claim or
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.

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.

How are complaints handled?

You, your provider, or your representatives can send a complaint in writing to us or to the Illinois Insurance Department.

When you send the complaint to us, we will let you know that we received your complaint and immediately start an investigation. A response will be sent to you within 15 working days from the receipt of the complain.

When we receive a complaint from the Illinois Department of Insurance, we will send a response within 21 calendar days of the department's letter (unless specified earlier by the Insurance Department).

Our response will include a description of how and when you were covered with Principal Life, the policy provisions that we relied on, what has happened with your claim, and an explanation of the final decision.

We maintain a complaint register that allows individual reconstruction of complaints as well as summary data



principal.com

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



A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM ENHANCED PLAN 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.



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.

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.

GET YOUR PERFECT PAIR

EXTRA \$20 +
TO SPEND ON
FEATURED FRAME BRANDS*

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LACOSTE  NINE WEST

SEE MORE BRANDS AT [VSP.COM/OFFERS](https://vsp.com/offers).

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TO **40%**
SAVINGS ON LENS
ENHANCEMENTS



Contact us: **800.877.7195** or vsp.com

YOUR VSP VISION BENEFITS SUMMARY

Enhanced Plan and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	<ul style="list-style-type: none">Focuses on your eyes and overall wellness	\$10	Every 12 months
PRESCRIPTION GLASSES			
FRAME	<ul style="list-style-type: none">\$150 allowance for a wide selection of frames\$170 allowance for featured frame brands20% savings on the amount over your allowance\$80 Costco® & Walmart® frame allowance	\$0	Every 12 months
LENSES	<ul style="list-style-type: none">Single vision, lined bifocal, and lined trifocal lensesImpact-resistant lenses for dependent children	\$0	Every 12 months
LENS ENHANCEMENTS	<ul style="list-style-type: none">Standard progressive lensesPremium progressive lensesCustom progressive lensesAverage savings of 20-25% on other lens enhancements	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none">\$150 allowance for contacts; copay does not applyContact lens exam (fitting and evaluation)	Up to \$60	Every 12 months
DIABETIC EYECARE PLUS PROGRAM SM	<ul style="list-style-type: none">Retinal screening for members with diabetesAdditional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor details.	\$0 \$20 per exam	As needed
COMPUTER VISIONCARE (EMPLOYEE-ONLY COVERAGE)			
COMPUTER VISION EXAM	<ul style="list-style-type: none">Evaluates your needs related to computer use	\$10 for exam and glasses	Every 12 months
FRAME	<ul style="list-style-type: none">\$90 allowance for a wide selection of frames\$110 allowance for featured frame brands20% savings on the amount over your allowance	Combined with exam	
LENSES	<ul style="list-style-type: none">Single vision, lined bifocal, lined trifocal, and occupational lenses		
EXTRA SAVINGS	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none">Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details.20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. <p>Routine Retinal Screening</p> <ul style="list-style-type: none">No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam <p>Laser Vision Correction</p> <ul style="list-style-type: none">Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

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.

Exam	up to \$45	Lined Bifocal Lenses	up to \$50	Progressive Lenses	up to \$50
Frame	up to \$70	Lined Trifocal Lenses	up to \$65	Contacts	up to \$105
Single Vision Lenses	up to \$30				

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. 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.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

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VSP, VSP Vision Care for life, Eyeconic, and WellVision Exam are registered trademarks, VSP Diabetic Eyecare Plus Program is servicemark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners.

Group Term Life and AD&D

Frontier North America

Group Term Life and Accidental Death and Dismemberment (AD&D) continues to be one of the most important and best values of all employee benefits. For many employees, Group Term Life insurance is the only life insurance they have.

<u>Class Description</u>	<u>Life</u>	<u>AD&D</u>
All Full-Time Employees	\$20,000	\$20,000

BASIC LIFE AND AD&D REDUCTION SCHEDULE		
CLASS DESCRIPTION	PERCENT REDUCTION	AT AGE
All Full-Time Employees	35%	65
	50%	70

- Benefits terminate at retirement unless provided for in the Schedule of Benefits.
- Basic Life insurance includes waiver of premium.

AD&D benefits are equal to the amount of Life benefits. The full AD&D benefit is payable for the following losses if such loss is the result of an accident: loss of life, loss of both hands or both feet, loss of sight in both eyes, loss of a hand and a foot, loss of a hand or a foot and the sight of one eye. Half of the AD&D benefits is payable for the following losses if such loss is the result of an accident: loss of a hand, loss of a foot, loss of the sight in one eye. The loss must occur within 90 days of the date of the accident. Total payment arising out of one accident may not exceed the amount for which the employee is insured.

Waiver of Premium - If an employee is totally and permanently disabled prior to age 60, Life coverage will be continued without payments of premium subject to any scheduled reductions and terminations. The employee may apply for this benefit after 12 months of total and continuous disability. Coverage continues for eligible employees whether or not the master policy remains in force but terminates at the earlier of retirement or age 65.

Conversion Privilege - Employees may convert to an individual life policy within 31 days of leaving active employment. No evidence of insurability will be required.

Accelerated Benefit - For Basic Group Life policies with employee coverage amounts of \$10,000 or more, an eligible employee as of the policy effective date who becomes terminally ill while covered by Companion Life can immediately access 75% of their benefit (maximum \$100,000) without administrative or interest charges. Employees enrolled after the initial policy effective date become eligible for this benefit after one year of continuous coverage.



P.O.Box 100102 . Columbia, SC 29202-3102 . 800-753-0404 . 800-836-5433 Fax . CompanionLife.com

This outline of coverage for life and AD&D is not a contract. Full details of the coverage are included in the certificate of coverage and master policy from Companion Life. Plan is administered and underwritten by Companion Life.



This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this document and the master policy, master policy provisions will prevail.

Northwest Employers Marketplace, Administered by Evergreen Security Trust

Policy WA300625

Life and Accidental Death & Dismemberment (AD&D)																														
Basic Life Insurance	\$10,000																													
Basic AD&D Insurance	\$10,000																													
Age Reduction	If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85 and to 10% at age 90.																													
AD&D Schedule	If due to an accident you die, lose a limb, sight of an eye or become paralyzed, the following benefits are available. <table><tr><td><u>100% of the Basic AD&D</u></td><td><u>75% of the Basic AD&D</u></td><td><u>50% of the Basic AD&D</u></td></tr><tr><td>Life</td><td>Paraplegia</td><td>One hand</td></tr><tr><td>Both hands</td><td>Triplegia</td><td>One foot</td></tr><tr><td>Both feet</td><td></td><td>Sight of one eye</td></tr><tr><td>Sight of both eyes</td><td><u>25% of the Basic AD&D</u></td><td>Speech or hearing</td></tr><tr><td>One hand and one foot</td><td>Thumb and Index finger</td><td>Hemiplegia</td></tr><tr><td>One hand and sight of one eye</td><td>Uniplegia</td><td></td></tr><tr><td>One foot and sight of one eye</td><td></td><td></td></tr><tr><td>Quadriplegia</td><td></td><td></td></tr></table>			<u>100% of the Basic AD&D</u>	<u>75% of the Basic AD&D</u>	<u>50% of the Basic AD&D</u>	Life	Paraplegia	One hand	Both hands	Triplegia	One foot	Both feet		Sight of one eye	Sight of both eyes	<u>25% of the Basic AD&D</u>	Speech or hearing	One hand and one foot	Thumb and Index finger	Hemiplegia	One hand and sight of one eye	Uniplegia		One foot and sight of one eye			Quadriplegia		
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Seat Belt Benefit	If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of \$10,000 in addition to the Basic Life and Basic AD&D benefits described above.																													
Accelerated Benefit	You may collect part of your Basic Life insurance prior to death if you are diagnosed as terminally ill and have a life expectancy of less than 24 months. You may apply for up to 80% of the Basic Life insurance in force, to a \$8,000 maximum. The remaining benefit you do not elect is payable to your beneficiary upon your death.																													
Total Disability	If you become totally disabled (as defined by the policy) prior to age 60 and are disabled for at least 6 consecutive months, your basic life insurance may be continued until you reach age 65 without further premium payment by either your employer or you. At age 65 coverage terminates, however you may continue coverage by applying for a conversion policy at that time.																													
Repatriation	If death occurs more than 100 miles from your primary residence, we will pay the lesser of; the actual expense, 10% of the Life benefit or \$5,000 to prepare and ship your body to the place of burial or cremation.																													
Additional AD&D Benefits Included	Adaptive Home/Vehicle, AirBag, Child Education, Coma, Day Care, Exposure and Disappearance, Felonious Assault, Spouse Education.																													
Basic Life Insurance Exclusions	None																													
AD&D Insurance Exclusions	Benefits are not payable for losses due to suicide or attempted suicide, riot, war or act of war, military service, committing or attempting to commit an assault or felony, use of drugs (legal or illegal) unless prescribed by and used in accordance with directions of the prescribing physician, bacterial or viral infections not the result of an injury, heart attack or stroke, travel and flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight and intoxication at or above the state legal limit.																													
Conversion	You may convert your Basic Life insurance to an individual policy if your coverage is terminated due to termination of employment or other loss of eligibility. You have 31 days from the earliest of, the date your employment terminates or other loss of eligibility to apply for the Conversion policy.																													