Benefit Summary
Provail
Group Number: 1651900

KAISER PERMANENTE®

Effective Date 7/1/2024	**Health Plan** Core HMO	**Ref** RQ-194815

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

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

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

Benefits	**Inside Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $7,500 per calendar year
Individual deductible carryover	4th quarter carryover applies
Plan coinsurance	Plan pays 80%, you pay 20%
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $12,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$35 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $35 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$40/$60 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $35 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$35 copay, deductible and coinsurance apply
Hearing hardware	$3,000 per ear every 36 months
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $35 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $35 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $35 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$35 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full

Benefit Summary
Provail
Group Number: 1652000

KAISER PERMANENTE

Effective Date 7/1/2024	**Health Plan** Core HMO	**Ref** RQ-194816

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

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

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- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $1,500 per calendar year Family deductible: $3,000 per calendar year
Individual deductible carryover	4th quarter carryover applies
Plan coinsurance	Plan pays 80%, you pay 20%
Deductible and/or coinsurance waiver riders	Covered at outpatient services copay for 1st 10 office visits per calendar year (deductible and coinsurance waived), after the 10 visits, covered at deductible and coinsurance (copay waived)
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $8,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$35 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $35 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$40/$60 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $35 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and/or coinsurance apply, then deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$35 copay, deductible and coinsurance apply
Hearing hardware	$3,000 per ear every 36 months
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $35 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $35 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $35 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$35 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full

Benefit Summary
Provail
Group Number: 8154100

KAISER PERMANENTE®

Effective Date 7/1/2024	**Health Plan** Access PPO	**Ref** RQ-194817

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

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

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- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $1,500 per calendar year Family deductible: $3,000 per calendar year	Individual deductible: $3,000 per calendar year Family deductible: $6,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Covered at outpatient services copay for 1st 10 office visits per calendar year (deductible and coinsurance waived), after the 10 visits, covered at deductible and coinsurance (copay waived)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $8,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit:No limit Family out-of-pocket limit: No limit Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$35 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$35/$55 ($15/$30/$50 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 15 visits per calendar year without prior authorization; additional visits when approved by the plan $35 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$35 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	$3,000 per ear every 36 months	Benefit shared with preferred provider network
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 15 visits per calendar year without prior authorization; additional visits when approved by the plan $35 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$35 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply	Not covered

Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $35 copay, deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $35 copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full	**Telemedicine:** Applicable cost shares apply **Telephone Services and Online (E-Visits):** Not Covered

DENTAL BENEFITS GUIDE

Welcome to your employer-sponsored dental coverage! Don't know where to start? No problem!

Taking charge of your oral health can directly impact your overall health. So, follow these 4 simple steps to a healthy, happy smile.

For more information, check out our Dental Benefits Guide online at: https://www.deltadentalwa.com/dental-benefits-guide

1 SIGN UP FOR MYSMILE® TO PUT YOUR DENTAL BENEFITS IN THE PALM OF YOUR HAND!

What's MySmile® ? It's how you use your benefits!

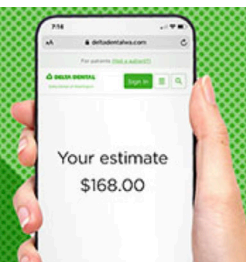
This easy-to-use online tool is the best way to access your coverage – anytime, anywhere.

Not only will you get a simple breakdown of your benefits, but you'll have access to a whole host of online tools and resources, including:

- Find a Dentist
- Cost Estimator
- Digital ID Card
- Benefit information including usage, claims status, and coverage overview
- And more!

And the best part? Signing up is free and easy. Learn more at: deltadentalwa.com/mysmile

GET STARTED WITH MYSMILE®



2 FINDING A DENTIST THAT'S RIGHT FOR YOU HAS NEVER BEEN EASIER.

Use our Find a Dentist™ tool to search for an in-network provider. It's as easy as 1-2-3.

Looking for a dentist close to home, one that has great patient recommendations, or hours that work with your schedule?

Log into MySmile® to generate results based on your specific network: deltadentalwa.com/mysmile

WHY CHOOSE AN IN-NETWORK DENTIST?

Because it's one of the best ways to get the most value out of your coverage!

Plus, in-network dentists will:

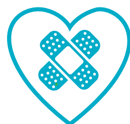
- Provide treatment according to each plan's specific guidelines
- Agree to accept lower fees
- File all claim forms for you

In other words: **it's cheaper and easier for you.** Now that's something to smile about.

3 LEARN HOW PREVENTIVE DENTAL CARE CAN HELP YOU STAY HEALTHY FROM HEAD-TO-TOE.

Good oral habits go beyond just simple brushing and flossing. Visit your dentist for regular cleanings and checkups, to keep on top of oral health issues – before they get out of control. It can save you quite a bit of moolah down the road.

And the benefits of good oral health don't stop at your pocketbook. Did you know that certain conditions like heart disease, pregnancy, diabetes, and even Alzheimer's are often first detected by your dentist?



HEART DISEASE

PREGNANCY

DIABETES

ALZHEIMER'S

Many of our plans cover preventative care visits at 100% with no out-of-pocket cost, so you can be sure you're taken care of from head to toe.

Learn more at: https://www.DeltaDentalWA.com/blog

4 THE 5 DENTAL BENEFIT TERMS YOU NEED TO KNOW

Dental benefit terms got you scratching your head? Well, have no fear! We've compiled a list of the 5 most common terms you'll come across and we're breaking them down below.

ANNUAL MAXIMUM

The total dollar amount your plan pays for your dental care within one benefit period. So, if your annual maximum is $2500, your plan pays a total of $2500 for the year. You are responsible for paying costs above the annual maximum directly to your dentist.

For many plans, preventive and diagnostic services don't count toward your annual maximum. This means you won't pay out-of-pocket costs for services like cleanings and x-rays, regardless of whether or not you've reached your annual maximum.

When your benefit year is over, your annual maximum resets for the new year.

COINSURANCE

The **amount you are responsible for paying toward your dental bill after we've paid our portion.** Coinsurance is usually expressed in a percentage.

For example, let's say your plan covers fillings at 80% of the total cost. That means we'll pay your dentist 80% of the total cost of the filling and you are responsible for the remaining 20%.

DEDUCTIBLE

The amount you must pay out-of-pocket before your plan starts covering your bill.

So, let's say you receive a bill for $1000 and your plan's deductible is $250. You're responsible for paying that $250 before your plan will pay the difference.

Many plans waive the deductible for services like cleanings or x-rays. So, check you plan details to see if you can get a check-up with no out-of-pocket costs.

4 THE 5 DENTAL BENEFIT TERMS YOU NEED TO KNOW (CONTINUED)

CONFIRMATION OF TREATMENT AND COSTS (COTC)

If you need major dental work, ask your dentist for a pre-treatment estimate.

After they contact us, we'll outline how much of the costs your plan will cover.

This document is called a Confirmation of Treat-ment and Cost or COTC.

This will give you an idea of what your treatment will costs, how much your plan will cover, and what your out-of-pocket costs might be.

Note: COTCS are only good for 180 days, after that, be sure to get an updated one before you have dental work done.

EXPLANATION OF BENEFITS (EOB)

The document you receive after your treatment is called an Explanation of Benefits or EOB.

Your EOB is not a bill. Instead, this document shows you how much of your coverage was applied to your treatment, how much coverage you have left, and the amount, if any, out-of-pocket costs you must pay.

FOR MORE INFORMATION OR TO REVIEW YOUR COVERAGE, LOG INTO MYSMILE® AT DELTADENTALWA.COM/MYSMILE

Still need help? Contact us, we're happy to help.

Call us 800.554.1907
Text us 833.604.1246
Visit DeltaDentalWA.com

Delta Dental of Washington

DELTA DENTAL | Delta Dental of Washington

PROVAIL
Group #09980

Delta Dental PPO℠ Base Plan
Benefit Summary

Effective Date	July 1, 2024
Benefit Period	January 1 – December 31
Benefit Period Maximum (Per Person)	$1,000

	Dental Network		
	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I (Per Person/Per Family)	**$25/$75**	$50/$150	$50/$150
Class I – Diagnostic & Preventive – Benefits do not accumulate towards your annual maximum			
Exams Cleaning Fluoride X-Rays Sealants	**100%**	100%	100%
Class II – Restorative			
Fillings Endodontics (Root Canal) Periodontics Oral Surgery General Anesthesia/IV Sedation	**80%**	80%	80%
Class III – Major			
Dentures Partial Dentures Implants Bridges Crowns	**0%**	0%	0%

This is a summary of benefits for comparison and isn't a contract. Once you're enrolled, you can get a benefits booklet that will provide all the details of your dental plan. Please feel free to call our customer service department or visit our website at **DeltaDentalWA.com** if you have any questions.

Keep in mind, you will likely experience the greatest savings when you see a Delta Dental PPO dentist.

DELTA DENTAL | Delta Dental of Washington

Get the most from your benefits!

Create a MySmile® account

It gives you secure, 24/7 access to your ID card, benefits information, out-of-pocket cost estimates, and more! Our "Find your member ID" tool makes registration easy. Visit DeltaDentalWA.com to create your account.

Choose an in-network dentist

Your plan gives you access to the Delta Dental PPO℠ network. Your benefits go farthest when you visit a Delta Dental PPO dentist which gives you the most bang for your buck.

If you see a NON-Delta Dental PPO dentist, you won't maximize your benefits. Your annual maximum won't go as far, and you'll likely have greater out-of-pocket costs.

	Delta Dental PPO	Delta Dental Premier	Non-Delta Dental
Your plan's network	✓		
Benefits go farthest which means least out-of-pocket costs	✓		
Files claims forms for you	✓	✓	
Comes with our quality management and cost protection	✓	✓	
No cost protection which means greatest out-of-pocket costs			✓

Find an in-network dentist near you:

1. Visit **DeltaDentalWA.com**
2. Click on 'Online Tools' and use our 'Find a Dentist' tool
3. Select 'Delta Dental PPO' to filter your search results

Visit your dentist regularly

Your plan covers preventive care visits each year. Regular cleanings and check-ups are essential to keeping your smile healthy and preventing painful, expensive problems down the road.

Get out-of-pocket cost estimates

Knowing your cost upfront helps you and your dentist plan treatments to maximize your benefits.

MySmile Cost Genie℠ gives you instant, cost estimates. It's great for basic treatments like fillings. Simply sign into MySmile account to get your personalized estimate.

When you need extensive treatment, like a crown, ask your dentist for a "Predetermination." You'll get a **Confirmation of Treatment and Cost** from us. It details your dentist's treatment plan, what your benefits cover, and how much you may owe your dentist for the treatment.

Still have questions? Contact us, we're happy to help.

Call 800.554.1907, Monday – Friday from 7am to 5pm, Pacific Time

Text 833.604.1246, Monday – Friday from 7am to 5pm, Pacific Time

Visit DeltaDentalWA.com

DELTA DENTAL® Delta Dental of Washington

PROVAIL
Group #09981

Delta Dental PPO℠ Buy-Up Plan
Benefit Summary

Effective Date	July 1, 2024
Benefit Period	January 1 – December 31
Benefit Period Maximum (Per Person)	$1,500
Orthodontia – Child Only Lifetime Maximum (Per Person)	50% $1,500

	Dental Network		
	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I (Per Person/Per Family)	**$25/$75**	$25/$75	$25/$75
Class I – Diagnostic & Preventive – Benefits do not accumulate towards your annual maximum			
Exams	**100%**	100%	100%
Cleaning			
Fluoride			
X-Rays			
Sealants			
Class II – Restorative			
Fillings	**80%**	80%	80%
Endodontics (Root Canal)			
Periodontics			
Oral Surgery			
General Anesthesia/IV Sedation			
Class III – Major			
Dentures	**50%**	50%	50%
Partial Dentures			
Implants			
Bridges			
Crowns			

This is a summary of benefits for comparison and isn't a contract. Once you're enrolled, you can get a benefits booklet that will provide all the details of your dental plan. Please feel free to call our customer service department or visit our website at **DeltaDentalWA.com** if you have any questions.

Keep in mind, you will likely experience the greatest savings when you see a Delta Dental PPO dentist.

DELTA DENTAL | Delta Dental of Washington

Get the most from your benefits!

Create a MySmile® account

It gives you secure, 24/7 access to your ID card, benefits information, out-of-pocket cost estimates, and more! Our "Find your member ID" tool makes registration easy. Visit DeltaDentalWA.com to create your account.

Choose an in-network dentist

Your plan gives you access to the Delta Dental PPO℠ network. Your benefits go farthest when you visit a Delta Dental PPO dentist which gives you the most bang for your buck.

If you see a NON-Delta Dental PPO dentist, you won't maximize your benefits. Your annual maximum won't go as far, and you'll likely have greater out-of-pocket costs.

	Delta Dental PPO	Delta Dental Premier	Non-Delta Dental
Your plan's network	✓		
Benefits go farthest which means least out-of-pocket costs	✓		
Files claims forms for you	✓	✓	
Comes with our quality management and cost protection	✓	✓	
No cost protection which means greatest out-of-pocket costs			✓

Find an in-network dentist near you:

1. Visit **DeltaDentalWA.com**
2. Click on 'Online Tools' and use our 'Find a Dentist' tool
3. Select 'Delta Dental PPO' to filter your search results

Visit your dentist regularly

Your plan covers preventive care visits each year. Regular cleanings and check-ups are essential to keeping your smile healthy and preventing painful, expensive problems down the road.

Get out-of-pocket cost estimates

Knowing your cost upfront helps you and your dentist plan treatments to maximize your benefits.

MySmile Cost Genie℠ gives you instant, cost estimates. It's great for basic treatments like fillings. Simply sign into MySmile account to get your personalized estimate.

When you need extensive treatment, like a crown, ask your dentist for a "Predetermination." You'll get a **Confirmation of Treatment and Cost** from us. It details your dentist's treatment plan, what your benefits cover, and how much you may owe your dentist for the treatment.

Still have questions? Contact us, we're happy to help.

Call 800.554.1907, Monday – Friday from 7am to 5pm, Pacific Time
Text 833.604.1246, Monday – Friday from 7am to 5pm, Pacific Time
Visit DeltaDentalWA.com

DELTA DENTAL® Delta Dental of Washington

DeltaVision® In Partnership with VSP®

DeltaVision - 200 LC benefit highlights

Now you can enjoy the benefits of comprehensive vision care. DeltaVision®, delivered in partnership with VSP® Vision Care, offers the quality coverage, exceptional service, and unparalleled networks you've come to enjoy with Delta Dental.

WellVision Exam®		**$10 Copay**
Exams Once every 12 months	Annual eye exam to ensure overall visual wellness.	
Essential Medical Eye Care		**$20 Copay**
Retinal imaging for members with diabetes covered-in-full. 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 network doctor for details. Available as needed.		
Prescription glasses		**$25 Copay**
Frames Once every 24 months	• $200 allowance for wide selection of frames – 20% savings on amount over allowance • $200 Walmart/Sam's Club frame allowance • $110 Costco frame allowance	Included in prescription glasses copay
Lenses Once every 12 months	• Single vision, lined bifocal, lined trifocal and lenticular lenses	Included in prescription glasses copay
Covered lens enhancements	• Impact-resistant lenses for children • Standard Progressive lenses • Average savings of 30% on other lens enhancements	$0
Elective contact lenses - instead of glasses		
Contacts Once every 12 months	• $200 allowance for contacts	$0 Copay
	• Contact lens exam (fitting and evaluation)	$60 or the VSP Doctor's fee, whichever is less
VSP LightCare™		
With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts. Frequency and Copay follows elected plan for materials.		

Continued on back page ▶

Extra savings	
Featured frames	Additional $20 allowance on Featured Frame Brands. Check vsp.com for current offers.
Glasses and sunglasses	20% savings on additional prescription and non-prescription glasses/sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam®
Retinal screening	Member cost of $39 or less on routine retinal screening as an enhancement to a WellVision Exam®

Coverage with out-of-network providers (copays apply)

Exam - up to $45
Frame - up to $70
Single Vision Lenses - up to $30
Lined Bifocal Lenses - up to $50
Lined Trifocal Lenses - up to $65
Lenticular Lenses - up to $100
Progressive Lenses - up to $50
Elective Contact Lenses - up to $105
Necessary Contact Lenses - up to $210

Please Note: This is a summary of your benefits for comparison only and isn't a contract. Once you're enrolled, you will have access to your benefits booklet that provides more details of your vision plan. Policies are underwritten by Delta Dental of Washington, VSP is the vision plan administrator. Delta Dental and Delta Vision are registered trademarks of the Delta Dental Plans Association. VSP and WellVision Exam are registered trademarks, and VSP LightCare is a trademark of Vision Service Plan.

Disclaimer: Coverage with any retail chain may differ or may not apply.
Lens enhancements are not covered through an out-of-network provider.

Personalized Care

DeltaVision members receive quality care that focuses on their eyes and overall wellness. Our eye care provider will look for vision problems and signs of other health conditions.

Eyewear

Choose eyewear that's right for you and your budget. From classic styles to the latest designer fashions, there are hundreds of options for DeltaVision members.

Value and Savings

DeltaVision members receive great benefits on exams and eyewear at an affordable price.

Online

Visit **vsp.com** to find a provider near you, learn more about your vision benefits, and access claims.

Mobile App

Download the mobile app for Apple or Android. To download, visit the App Store (Apple) or Google Play (Android) and search for VSP.

Customer Service

Call VSP customer service representatives at 800.877.7195 and ask if your provider is participating in the VSP Doctor Network.

Group Life Insurance

Basic Life and Accidental Death & Dismemberment

SUMMARY OF BENEFITS

Class 1

Sponsored By: **PROVAIL**
Effective Date: **July 1, 2024**
Policy Number: **01-020939-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	Life Benefit
Amount	$15,000
Maximum Amount	$15,000
Guaranteed Issue	$15,000

Employee	AD&D Benefit
Amount	$15,000
Maximum Amount	$15,000

Benefit Reduction	Employee
Original Benefit Amount Reduced To	65% at age 65 50% at age 70

Eligibility

All Active Full-Time Employees working a minimum of 30 hours per week.

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag and Repatriation benefits. Please refer to your employee certificate for additional information.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020939-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

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Group Life Insurance

Supplemental Life and Accidental Death & Dismemberment

SUMMARY OF BENEFITS

Class 1

Sponsored By: **PROVAIL**
Effective Date: **July 1, 2024**
Policy Number: **01-020939-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	**Life Benefit**
Amount	Increments of $10,000
Minimum Amount	$10,000
Maximum Amount	Lesser of $300,000 or 5 x Earnings
Guaranteed Issue	$150,000

Spouse	**Life Benefit**
Spouse Amount	Increments of $5,000
Minimum Amount	$5,000
Maximum Amount	$150,000 not to exceed 100% of Supplemental Employee Coverage
Guaranteed Issue	$25,000

Child	**Life Benefit**
Child Amount	Live Birth to 26 year(s): $10,000

Employee	**AD&D Benefit**
Amount	Increments of $10,000
Minimum Amount	$10,000
Maximum Amount	Lesser of $300,000 or 5 x Earnings

Spouse	**AD&D Benefit**
Spouse Amount	Increments of $5,000
Minimum Amount	$5,000
Maximum Amount	$150,000 not to exceed 100% of Supplemental Employee Coverage

Child	**AD&D Benefit**
Child Amount	Live Birth to 26 year(s): $10,000

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SYMETRA
RETIREMENT | BENEFITS | LIFE

Benefit Reduction	Employee and Spouse
Original Benefit Amount Reduced To	65% at age 65 50% at age 70

Eligibility

All Active Full-Time Employees working a minimum of 30 hours per week and their eligible dependents.

Evidence of Insurability

Evidence of Insurability is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the Guarantee Issue amount.

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag and Repatriation benefits. Please refer to your employee certificate for additional information.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Rates for Supplemental Life coverage

Monthly Supplemental Employee and Spouse Life Rates per $1,000 of coverage

AGE	RATE
Under 25	$0.050
25 - 29	$0.060
30 - 34	$0.080
35 - 39	$0.090
40 - 44	$0.100
45 - 49	$0.150
50 - 54	$0.230
55 - 59	$0.430
60 - 64	$0.660
65 - 69	$1.270
70 - 74	$2.060
75 +	$2.060

Monthly Supplemental Child Life Rate per $1,000 of coverage is $0.0900
Monthly Supplemental Employee AD&D Rate per $1,000 of coverage is $0.0150
Monthly Supplemental Spouse AD&D Rate per $1,000 of coverage is $0.0150
Monthly Supplemental Child AD&D Rate per $1,000 of coverage is $0.0150

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Calculating Your Cost

Coverage	Volume		Rate		Monthly Cost
Supplemental Employee Life:	______ (volume)	x	______ (rate)	/1,000 =	$ ______ Monthly Cost
Supplemental Spouse Life:	______ (volume)	x	______ (rate)	/1,000 =	$ ______ Monthly Cost
Supplemental Child Life:	______ (volume)	x	0.090 (rate)	/1,000 =	$ ______ Monthly Cost
Supplemental Employee AD&D:	______ (volume)	x	0.015 (rate)	/1,000 =	$ ______ Monthly Cost
Supplemental Spouse AD&D:	______ (volume)	x	0.015 (rate)	/1,000 =	$ ______ Monthly Cost
Supplemental Child AD&D:	______ (volume)	x	0.015 (rate)	/1,000 =	$ ______ Monthly Cost

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020939-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

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Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Group supplemental life insurance

Can your family afford to lose your income?

You work hard to protect your family's financial future, but some hardships can't be predicted. If you suddenly pass away, the loss of your income can make a difficult situation for those who depend on you even worse.

If your family lost you as a provider, could they continue to make their mortgage payments, save for college or meet other financial obligations?

With supplemental group life insurance, you can help ensure your family has the financial protection they need. And by enrolling in this valuable insurance at work, you can take advantage of a simplified process.

Take advantage of a simplified process with:

- Less paperwork—just one enrollment form to complete.
- No medical questionnaires if you enroll during your initial eligibility period.[1]
- Convenient payroll deductions if any premium is owed.
- Flexible coverage amounts to meet your family's needs.

Ready to get started?

Review your enrollment packet.

Use the calculator on the next page to determine how much life insurance protection your family needs.

Complete and submit your enrollment form.

How much do I need?

Use this calculator to estimate how much life insurance you may need.

Final Expenses

How much money do you need to clear up short-term obligations and pay for final expenses? (Consider medical costs, funeral expenses and consumer debt.)

Total Final Expenses	**A**

Housing Expenses

How much money do you need to pay off your mortgage or cover your housing costs?

Total Housing Expenses	**B**

Income Replacement

How long do you want to extend your income stream?

Number of Years	
x Current Annual Income	
Total Income Replacement	**C**

Education Expenses

How much money will your children or grandchildren need to complete their education?

Annual Tuition	
x Number of Years	
x Number of Children	
Total Education Expenses	**D**

Total Life Insurance Needed Today

A + B+ C+ D =	$
minus	-
Current Life Insurance How much life insurance do you currently have?	$
equals	=
Total Life Insurance Deficit or Surplus	**$**

Did you know?

On average, U.S. residents have just 26% of the life insurance they need.[2]

Example

Meet Aaron

Nothing matters more to Aaron than his family. And while he wants to be there to provide for them, he also knows how important it is to ensure they're cared for if the worst happens. That's why he enrolled in his work's supplemental life insurance plan. He made sure he had enough insurance to cover his family's bills, pay off the house and send his daughter to college if he unexpectedly passed away.

How much life insurance does Aaron need?

Aaron used the life insurance calculator on the previous page to figure out how much coverage to get.
Here's a summary of his results:

Housing Expenses	**$200,000**
Income Replacement How long do you want to extend your income stream?	
Number of Years	10
x Current Annual Income	$60,000
Total Income Replacement	**$600,000**
Education Expenses	**$40,000**
Total Life Insurance Needed	**$840,000**
Current Individual Life Insurance	**$500,000**
Supplemental Life Insurance needed	**$340,000**

This example is for illustrative purposes only. Refer to your complete benefit materials for specifics about your plan.

To learn more, contact your benefits representative.

www.symetra.com
www.symetra.com/ny

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Symetra Life Insurance Company is a direct subsidiary of Symetra Financial Corporation. First Symetra National Life Insurance Company of New York is a direct subsidiary of Symetra Life Insurance Company and is an indirect subsidiary of Symetra Financial Corporation (collectively, "Symetra"). Neither Symetra Financial Corporation nor Symetra Life Insurance Company solicits business in the state of New York and they are not authorized to do so. Each company is responsible for its own financial obligations.

Group life policies, insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, are not available in any U.S. territory. Base certificate form number is LGC-13500-CERT 08/06. Coverage may be subject to exclusions, limitations, reductions and termination of benefit provisions. For costs and complete details of the coverage, contact your HR representative.

In New York, group life policies are insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124. Policy form number is LGC-03300/NY 1/14.

[1] Up to the maximum guaranteed issue amount.

[2] "What can we do about Under-Insurance in the USA?" Atidot. Published January 2019, https://www.atidot.com/under-insurance-report-2018-ind.