PLU's Good Fit Medical Plan Options effective 6/1/2014

	Alliant Plus		Group Health Essentials
Providers	**In-Network** Group Health doctors and clinicians and nearly 6,500 contracted providers, *plus Virginia Mason and Everett Clinic medical centers*	**Out-of-Network** First Choice, **First Health** and MedImpact Pharmacies or any licensed provider	**In-Network** Group Health doctors and clinicians and nearly 6,500 contracted providers.
Deductible Deductible does not apply to preventive care, prescription drugs or vision exams/ hardware.	Deductible combined, whether for in or out of network care: **$500** *(was $350)* /individual, **$1,000** *(was $700)* /family		$1,000/individual, $2,000/family
Out-of-Pocket (OOP) Maximum	OOP Maximum combined for in and out of network care: **$3,500** *(was $3,000)* /individual; **$7,000** *(was $6,000)* /family **Includes deductible, office copays & Rx copays**		**$3,000** *(was $2,000)*/individual **$6,000** *(was $4,000)*/family **Includes deductible, office copays & Rx copays**
Lifetime Maximum	Unlimited		Unlimited
Office Calls (Visits)	$30 copay, then 100%	$30 copay, then 80%	$30 copay, then 80%
Hospitalization			
Emergency Rm Copay	**$150** *(was $100)*	**$150** *(was $100)*	**$150** *(was $100)* in and & out-of network
Outpatient	**100%**	80%	80%
Inpatient	**100%**	80%	80%
Preventive Care	**Not subject to deductible** 100% (no copay)	**Not subject to deductible** 100% ($30 copay) (Routine Mammograms- covered in full)	**Not subject to deductible** 100% (no copay)
Prescriptions	**Not subject to deductible**	**Not subject to deductible**	**Not subject to deductible**
Preferred Generic	$15 copay / 30-day supply	$20 copay / 30-day supply	$15 copay / 30-day supply
Preferred Brand	$30 copay / 30-day supply	$35 copay / 30-day supply	$30 copay / 30-day supply
Non-Preferred Generic/Brand	**$50 copay / 30-day supply**	**$55 copay/ 30-day supply**	**n/a**
Mail Order	90-day supply for 2 copays	Only available if dispensed thru GH designated mail order service	90-day supply for 2 copays (on the GH preferred list)
Vision	**Not subject to deductible**	**Subject to deductible**	**Not subject to deductible**
Eye Exam	1 per 12 months; $30 copay	1 per 12 months; $30 copay; then 80%	1 per 12 months; $30 copay
Hardware- up to **$250** in 24-month period for age 19+; (for age 18 & under, see Summary for details)	**Not subject to deductible** Hardware through GH Eye Care Centers only	**Not subject to deductible** Hardware available from any licensed provider	**Not subject to deductible** Hardware through GH Eye Care Centers only
Chiropractic	100% ($30 copay) 10 visits per year combined for in and out of network care	80% ($30 copay)	80% ($30 copay) 10 visits per year
Hearing Benefit	$1,000 per ear every 36 months (hardware)		
Other benefits	See GH Summary of Benefits for details		
Out of network	N/A	See above	None except emergencies

Monthly Rates	Alliant Plus	GH Essentials	
	PLU's contribution - $516.78 *(was $479.75)*		**PLU's contribution**
Employee Only	**$27.20** *(was $25.25)*	**$5.00** *(no change)*	**$391.94** *(was $367.87)* plus **$75.00/mo ($900/year)** deposited to Flexible Spending Account
With a Spouse/ Domestic Partner	**$571.18** *(was $530.25)*	**$285.08** *(was $267.79)*	**$510.72** *(was $479.75)*
With a Spouse/DP + 1 child	**$845.86** *(was $785.25)*	**$444.51** *(was $417.56)*	**$555.06** *(was $521.39)*
With Spouse/DP + 2 or more children	**$1,142.09** *(was $1,060.25)*	**$603.94** *(was $567.31)*	**$599.38** *(was $563.04)*
With 1 child	**$301.88** *(was $280.25)*	**$55.69** *(was $52.31)*	**$545.01** *(was $511.97)*
With 2 or more children	**$581.95** *(was $540.25)*	**$195.00** *(was $183.17)*	**$609.42** *(was $572.46)*

This is a brief comparison of the **Good Fit** *medical plans' major benefit provisions. It is not intended to provide you with a full description. All benefits are subject to the terms and conditions of the group medical coverage agreement. If you have questions about a particular benefit, please contact PLU's Human Resources at x7185.*

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PLU's Good Fit Dental Plan Options effective 6/1/2014

	Delta Dental of WA		Willamette Dental of WA, Inc.
	In network	*Out of network*	
Provider Network	**Preferred** Provider	**Premier** Provider (to limit your balance to PLU's coinsurance difference and ensure direct billing)	All care must be obtained from a Willamette Dental Clinic. There are more than 25 locations throughout Washington including: • Federal Way: 181-South 333rd Street, Suite C-100 • Kent: 24722 104th Ave SE, Ste 200 • Lakewood: 9307 Bridgeport Way S.W. • Olympia: 3773-C Martin Way, Suite 105 • Puyallup: 702 South Hill Park Drive, Suite 201 • Renton: 1000 Oaksdale Avenue SW, Suite 100 • Seattle: 133 Dexter Avenue North • Silverdale: 3505 Anderson Hill Road • Tacoma: 5401-6th Avenue, Suite 201 • Tumwater: 6120 Capital Boulevard South SE *Call 1-800-359-6019 for a complete locations list.*
	Go to www.deltadentalwa.com or call **1-800-554-1907**		
Deductible – Annual *calendar* year Waived for Class 1?	 $50 *Yes*	 *$100* *Yes*	 No deductible N/A
Office call copayments	None	None	$15 (Missed appointment = $30) Specialist = $30 ER during office hours = $50 ER after office hours = $70
Class 1 – Preventive Care Cleanings, x-rays, fluoride treatments	100%	90%	100%
Class II – Basic Care Fillings, extractions	80%	60%	100% for fillings & extractions 100% for surgical extractions, bone surgery and root planing
Class III – Major Care Inlays, onlays & dentures	50%	30%	*$150* copay/tooth for bridges & crowns *$275* complete denture (upper or lower) $150/tooth (pontic, cast, bridge pontics) *$75, $90,$125 copay root canals* *$80 copay for surgical extractions* Implants – see updated schedule for copays
Class IV – Orthodontics	None	None	Applies toward orthodontic copayment: • Initial orthodontic exam $25 • Study models and X-rays $125 • Cast presentation $0 Orthodontic service $1,500 copay
Calendar Year Maximum Per covered individual	$1,500	$1,500	No annual maximum except for TMJ at $1,000 per year to a lifetime maximum of $5,000
Waiting Periods	None	None	None

Monthly Rates, after PLU's contribution of $40.33 (at 95% of Willamette Dental Plan)		
Employee only	**$13.15** *(was $8.53)*	**$2.12** *(no change)*
With a Spouse/Domestic Partner	**$65.01** *(was $55.91)*	**$45.07** *(no change)*
With a Spouse/DP and Child or Children	**$128.38** *(was $113.80)*	**$96.17** *(no change)*
With a Child or Children	**$75.40** *(was $65.40)*	**$ 53.47** *(no change)*

This is a brief comparison of the **Good Fit** *medical plans' major benefit provisions. It is not intended to provide you with a full description. All benefits are subject to the terms and conditions of the group dental coverage agreement. If you have questions about a particular benefit, please contact PLU's Human Resources at x7185.*