PLU's Good Fit Medical Plan Options effective 6/1/2018

	Kaiser Permanente Access PPO		Kaiser Permanente Essentials (Core)
Providers	**In-Network** **Enhanced Benefit Provider:** Kaiser Permanente doctors and clinicians **Preferred Contracted providers,** including Access PPO, First Choice Health and OptumRx pharmacies	**Out-of-Network** Any licensed provider	**In-Network** Kaiser Permanente doctors and clinicians in 25 locations in Washington. 9,000 affiliated primary and specialty physicians
Deductible Deductible does not apply to preventive care, prescription drugs or vision exams/ hardware unless specified otherwise.	**Deductible combined, whether for in or out-of-network care** $750 /individual, $1,500/family		$1,000/individual, $2,000/family
Out-of-Pocket (OOP) Limit	$3,000/individual, $6,000/family **Includes all cost shares for covered services (deductible, coinsurance & copays)**		
Lifetime Maximum	Unlimited		
Office Calls (Visits)	**Deductible and coinsurance apply** No copay 95% (Enhanced Benefit Providers) 90% (Preferred Contracted Providers)	No copay 70%	**Deductible and coinsurance apply** $30 copay 80%
Hospitalization	**Deductible and coinsurance apply**		**Deductible and coinsurance apply**
Emergency Rm Copay	$150		$150
Outpatient	90%	70%	80%
Inpatient	90%	70%	80%
Preventive Care	**Not subject to deductible or coinsurance** 100%	**Deductible and Coinsurance apply** 70%	**Not subject to deductible or coinsurance** 100% (no copay)
Vision	**Not subject to deductible or coinsurance**		**Not subject to deductible or coinsurance**
Eye Exam	1 per 12 months, 100%		1 per 12 months, 100% $30 copay
Hardware	**Not subject to deductible or coinsurance** Up to **$250** in 24-month period for age 19+; (for age 18 & under, see Summary for details)		
Manipulative Therapy (Chiropractic)	**Deductible and coinsurance apply** 90% 15 visits per year combined for in-and-out-of-network care	70%	**Deductible and coinsurance apply** $30 copay, 80% 10 visits per year
Prescriptions	**IN-NETWORK ONLY - Not subject to deductible**		**Not subject to deductible**
Preferred Generic	$15 copay/30-day supply		$15 copay/30-day supply
Preferred Brand	$25 copay/30-day supply		$30 copay/30-day supply
Non-Preferred Generic/Brand	$45 copay/30-day supply		n/a
Mail Order	90-day supply for 2 copays		90-day supply for 2 copays
Pharmacy	Kaiser pharmacy; any of OptumRx's national network of 65,000 pharmacies Discount for Preferred & Non-Preferred prescriptions: $5 less when obtained at a Kaiser pharmacy		Kaiser pharmacy
Hearing Benefit	$1,000 per ear every 36 months (hardware)		
Other Benefits	See Kaiser Summary of Benefits for details		

Monthly Rates	Access PPO	PLU's contribution	Essentials (Core)	PLU's contribution
Employee Only	$55.10 *(was $50.10)*	$661.12 *(was $598.98)*	$20.00 *(was $15.00)*	$515.54 *(was $483.06)*
With a Spouse/ Domestic Partner	$686.28 *(was $676.28)*	$746.18 *(was $621.90)*	$312.32 *(was $302.32)*	$761.38 *(was $696.22)*
With a Spouse/DP + 1 child	$1,002.48 *(was $992.48)*	$791.64 *(was $633.46)*	$481.42 *(was $471.42)*	$867.20 *(was $782.80)*
With Spouse/DP + 2 or more children	$1,343.48 *(was $1,333.48)*	$840.68 *(was $645.94)*	$650.48 *(was $640.48)*	$973.04 *(was $869.40)*
With 1 child	$371.30 *(was $366.30)*	$706.60 *(was $610.56)*	$64.06 *(was $59.06)*	$746.42 *(was $694.68)*
With 2 or more children	$693.68 *(was $688.68)*	$752.96 *(was $622.36)*	$211.80 *(was $206.80)*	$873.54 *(was $802.56)*

PLU's Good Fit Medical Plan Options effective 6/1/2018

	Kaiser Permanente HSA HMO	
Providers	**In-Network** Kaiser Permanente doctors and clinicians in 25 locations in Washington. 9,000 affiliated primary and specialty physicians	
Deductible Deductible does not apply to preventive care. It does apply to all other services, including prescription drugs.	**Single (Employee Only)** $1,500	**Family (Employee + Any Dependents)** $3,000
Out-of-Pocket (OOP) Limit	**Single (Employee Only)** $3,500	**Family (Employee + Any Dependents)** $7,000
	Includes all cost shares for covered services (deductible, coinsurance & copays)	
Lifetime Maximum	Unlimited	
Office Calls (Visits)	**Deductible and coinsurance apply** No copay; 80%	
Hospitalization	**Deductible and coinsurance apply**	
Emergency Rm Copay	No copay; 80%	
Outpatient	80%	
Inpatient	80%	
Preventive Care	**Not subject to deductible or coinsurance** 100%	
Vision	**Not subject to deductible or coinsurance**	
Eye Exam	1 per 12 months, 100%	
Hardware	**Not subject to deductible or coinsurance** Up to **$250** in 12-month period for age 19+; (for age 18 & under, see Summary for details)	
Manipulative Therapy (Chiropractic)	**Deductible and coinsurance apply** 80% 10 visits per year	
Prescriptions	**Subject to deductible (Copays apply only after deductible is met)**	
Preferred Generic	$15 copay/30-day supply	
Preferred Brand	$30 copay/30-day supply	
Non-Preferred Generic/Brand	n/a	
Mail Order	90-day supply for 3 copays (no discount on copays)	
Pharmacy	Kaiser pharmacy	
Hearing Benefit	Not covered on HSA plan, however is an eligible expense reimbursed by the HSA account	
Other Benefits	See Kaiser Summary of Benefits for details	

Monthly Rates	HSA HMO	
		PLU's contribution plus **$75.00/mo ($900/year) for HSA Individual / $150/mo ($1,800/year) for HSA Family** deposited into Health Savings Account
Employee Only	$15.00 *(was $10.00)*	$455.56 *(was $427.60)*
With a Spouse/ Domestic Partner	$215.32 *(was $205.32)*	$728.04 *(was $671.98)*
With a Spouse/DP + 1 child	$359.62 *(was $349.62)*	$825.32 *(was $752.34)*
With Spouse/DP + 2 or more children	$503.84 *(was $493.84)*	$922.64 *(was $832.74)*
With 1 child	$35.00 *(was $30.00)*	$677.12 *(was $632.24)*
With 2 or more children	$113.76 *(was $108.76)*	$839.84 *(was $778.06)*

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.*

PLU's Good Fit Dental Plan Options effective 6/1/2018

	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 22 locations throughout Washington including:** • Bellevue: 626 120th Avenue Northeast, Suite B210 • Federal Way: 181 South 333rd Street, Suite C-100 • Kent: 510 Washington Avenue North • Olympia: 3773-C Martin Way, Suite 105 • Puyallup: 702 South Hill Park Drive, Suite 201 • Seattle: 133 Dexter Avenue North • Silverdale: 3505 NW Anderson Hill Road, Suite 101 • Tacoma: 3866 South 74th Street, Suite 200 • Tumwater: 6120 Capital Boulevard South SE *Call 1-855-433-6825 for appointments or customer service*
	Go to www.deltadentalwa.com or call 1-800-554-1907		
Deductible – Annual *calendar* year Waived for Class 1?	 $50/$150 *Yes*	 $100/$300 *Yes*	 No deductible N/A
Office call copayments	None	None	$15 copay (Missed appointment = $30 fee) Specialist = $30 copay ER during office hours = $15 copay ER after office hours = $15 + $20 after hours copay
Class I – Preventive Care Cleanings, x-rays, fluoride treatments	100%	90%	100% after office visit copay
Class II – Basic Care Fillings, extractions	80%	60%	**Benefits Paid at 100% after applicable copays** 100% for fillings, routine extractions, osseous surgery and root planning
Class III – Major Care Inlays, onlays & dentures	50%	30%	**Benefits Paid at 100% after applicable copays** $150 copay/tooth for bridges & crowns $275 complete denture (upper or lower) $75, $90, $125 copay for root canals $50 copay for surgical extractions
Class IV – Orthodontics	No coverage		**Benefits Paid at 100% after applicable copays** • Pre-Orthodontic Treatment - Initial orthodontic exam $25* • Pre-Orthodontic Treatment - Study models and X-rays $125* • Case presentation $0 Orthodontic service $1,500 copay *Applies to Ortho co-pay if banded
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

Monthly Rates, after PLU's contribution of $42.94 *(was $42.94)*		
Employee only	**$9.06** *(was $9.06)*	**2.26 $** *(was $2.26)*
With a Spouse/Domestic Partner	**$60.06** *(was $60.06)*	**$48.06** *(was $48.06)*
With a Spouse/DP and Child or Children	**$121.06** *(was $121.06)*	**$102.50** *(was $102.50)*
With a Child or Children	**$70.06** *(was $70.06)*	**$57.00** *(was $57.00)*

This is a brief comparison of the **Good Fit** *dental 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.*