2025 Chamber Benefits Guide

Seattle Metropolitan Chamber of Commerce

January 1, 2025 - December 31, 2025

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EMPLOYEE BENEFIT BROCHURE 2025

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I. ELIGIBILITY

YOU MUST ENROLL FOR BENEFITS COVERAGE WITHIN YOUR FIRST 30 DAYS OF EMPLOYMENT.

Welcome to the Seattle Metropolitan Chamber of Commerce, its special programs and affiliated organizations, referred to as the "Organization" for ease of use in this brochure. You are eligible to participate in benefits if you are an employee who is regularly scheduled to work 20 hours or more per week. Your coverage becomes effective on the first day of the month following or coinciding with your date of hire. Eligible dependents include:

- Your legal spouse or domestic partner
- Your children (biological, adopted, foster children, stepchildren, or children for whom you have guardianship, children of domestic partner when your partner is also covered), regardless of their marital or student status up until the end of the month in which they turn 26.

If you choose to waive coverage through the Organization's benefits plan, you are required to submit a waiver of coverage, which is provided by Human Resources. If you choose to waive benefits at the time of hire, you will be required to wait until the next open enrollment period or until you experience a qualifying life event to be eligible to enroll in medical and non-medical benefits.

A. MAKING CHANGES DURING THE YEAR

Once selected, you may not change your benefits until the next open enrollment period, held each November, unless you experience a qualifying life event. These events include, but are not limited to:

- Marriage
- Birth, adoption, or gaining legal custody of a child
- Divorce or legal separation
- Loss of coverage under another group insurance plan
- Loss or gain of your spouse's or domestic partner's eligibility under their employer's benefit plan
- The death of your spouse, domestic partner, or a child

If you experience a qualifying life event, you must notify Human Resources to change your coverage within 30 days of the event; or 60 days if adding newborns or newly adopted children, if you, your spouse/domestic partner, or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (S-CHIP) or becomes eligible for state-provided assistance.

B. ANNUAL OPEN ENROLLMENT

Open enrollment is held annually in November and is your opportunity to evaluate your benefit options and to make changes for the upcoming calendar year.

1. Review your options by reading through open enrollment communications, check your current elections, and participate in available workshops or HR meetings.
2. Consider your needs for the year - look at previous claims and anticipate future needs.
3. Choose a health plan that's right for you. Aren't sure? Ask HR for a consultation!
4. If you are electing to enroll in the Flexible Spending Account and/or Dependent Care Spending Account, determine your annual contribution. You are required to re-enroll into this benefit each year.
5. Enroll using the SIMON online portal during the open enrollment period. If you are unable to use the online portal, contact HR for other enrollment options.

II. COMMON INSURANCE TERMS

The following definitions will help you better understand your health plan options, please see additional handouts for more detailed information:

- **Premium**: A cost that is deducted from your paycheck to provide you access to benefits.
- **Copayment or Copay**: A flat amount paid per visit or prescription.
- **Deductible**: An annual amount paid for services prior to receiving a coinsurance benefit.
- **Coinsurance**: A method of cost-sharing that requires the employee to pay a percentage of all remaining eligible medical expenses after the deductible amount has been paid.
- **Out-of-Pocket Maximum**: Once an employee has reached this annual amount, any further eligible costs for the plan year are covered 100% by the plan. This does not include copays and premiums.
- **Preventive Care**: Preventive care services are routine services that include screenings, check-ups, and patient counseling to prevent illnesses, disease or other health problems. Preventive care services and recommendations are defined by the U.S. Preventive Task Force. To find a complete list, visit Premera Blue Cross' site: http://smcc.bz/SMCCPPL or Kaiser Permanente's site: http://smcc.bz/SMCCKP.
- **In-Network Provider**: These hospitals and facilities have contracted with your insurance company to provide services at a negotiated rate. Your out-of-pocket costs will be lower if you choose to see an in-network provider.
- **Out-of-Network Provider**: These hospitals and facilities are not contracted with Premera and not part of their network of providers. Your out-of-pocket costs will be higher if you choose to see an out-of-network provider. Please note, Kaiser HMO plan does not cover out-of-network providers.
- **Explanation of Benefits (EOB)**: The EOB is a statement from the insurance company. The EOB lists what portion of a claim was paid by the plan and what portion of the payment, if any, you are responsible for.

III. MEDICAL INSURANCE PLANS

The Organization offers you a choice of medical plans, including an HMO (Health Maintenance Organization) plan through Kaiser Permanente and two Preferred Provider Organization (PPO) plans through Premera Blue Cross. Although the plans generally cover the same medical services, they are different in three important ways: what providers and facilities you have access to, how much money you spend when you receive services, and how much your annual deductible is. Which plan is best for you will depend on your and your family's health care needs.

**See the plan comparison chart on page 13 and plan summaries starting on page 16 for more detailed information*

A. KAISER PERMANENTE CORE HMO

The Kaiser Permanente Plan is a Health Maintenance Organization (HMO) plan. This plan has no deductible and requires copayment for certain services. To receive care, you must use a Kaiser Permanente provider or facility for services to be covered. You do not have to be referred by your primary care physician to see many specialists in network.

B. PREMERA TITANIUM 500 PRIME

The PPO Plan has an in-network annual deductible of $500 per individual and a maximum of $1,000 for a family. With the PPO plan, you pay a higher premium in exchange for the lower deductible and out-of-pocket maximum. If you receive care from an in-network provider, you will receive the highest level of benefit coverage available.

C. PREMERA STERLING 750 PLUS

This PPO Plan has an in-network annual deductible of $750 per individual and a maximum of $2,250 in-network family deductible and offers a larger network of providers than the Premera Titanium 500 Prime plan. With the PPO plan, you pay a higher premium in exchange for the lower deductible and out-of-pocket maximum. If you receive care from an in-network provider, you will receive the highest level of benefit coverage available.

D. NICE HEALTHCARE

Nice Healthcare is available to employees and their dependents under 18 years old on Chamber Medial Insurance Plans. Nice Healthcare provides chat, video, and home primary care visits at a low or no cost. The service also includes primary care labs, x-ray imaging, prescriptions, physical therapy, mental health therapy, wellness, pregnancy and chronic condition coaching.

IV. MEDICAL COSTS

Below is a brief overview of the cost to obtain medical insurance coverage through the Organization. The premium cost that employees pay for their own medical coverage is based on annual pay rate, hours worked per week, and employment tenure at the Organization. In the table below, "Premium Share" refers to the amount the employee is responsible for each month. Please see the employee handbook for more information.

For the first five years of employment, employees are considered "non-vested," and pay the employee premium share described below, depending on their annual pay rate, for their own medical insurance coverage. Non-vested employees pay 100% of medical, dental, and vision premiums for their covered dependents. In compliance with federal law, dependent children are eligible for coverage until they are 26 years old. Once an employee reaches five years of seniority, they are considered vested, and the cost for each dependent's coverage will reduce to match the employee's self-coverage premium costs.

Health Insurance, Monthly Costs - Non-Vested, Full-Time Employees*						
Plan	Employee Coverage	Employee & Spouse Coverage	Employee, Spouse, & 1 Child Coverage	Employee, Spouse, & 2+ Children Coverage	Employee & 1 Child Coverage	Employee & 2+ Children Coverage
Kaiser Permanente	*See Premium Share Cost Chart Below*	+ $1,213.74	+ $1,831.64	+ $2,371.45	+ $617.88	+ $1,157.66
Premera Sterling Plus $750 - Heritage Network		+ $960.63	+ $1,729.15	+ $1,729.15	+ $768.52	+ $768.52
Premera Titanium Prime $500 - Prime Network		+ $980.79	+ $1,765.45	+ $1,765.45	+ $784.67	+ $784.67

Premium Share Cost	
If your annual earnings are:	**Your monthly premium share is:**
Up to $49,999	$0.00
$50,000 – $74,999	$20.00
$75,000 – $99,999	$30.00
$100,000-$124,999	$40.00
$125,000 and above	$50.00

Examples:

1. For an employee who makes $75,000 annually and has worked at the Organization for 2 years, the cost to cover themselves is $30 per month, regardless of which medical insurance plan they select. To add a dependent, they would pay the additional premiums listed above.
2. For an employee who makes $75,000 annually and has worked at the Organization for 6 years, the cost to cover themselves and two dependents is $90 per month ($30 x 3).

Premiums for you, your spouse, and dependent children are deducted on a pre-tax basis. Pre-tax means the deductions are taken from your gross pay before federal withholding and Social Security taxes are calculated and withheld.

*For benefits-eligible employees working between 20-29 hours per week, please see page 14 for additional cost details.

V. VISION COSTS

Administered through Vision Service Plan (VSP)

Our contract requires all full-time employees, including those who waive out of medical insurance, to enroll in vision insurance. The Organization and our affiliates pay 100% of the premiums, so there is no cost to employees who work at least 30 hours per week. Employees with less than five years of service pay 100% of premiums for their covered dependents. See the plan document for a full listing of covered services and benefits.

Vision Insurance, Monthly Costs - Non-Vested, Full-Time Employees			
Employee	Employee & Spouse Coverage	Employee, Spouse & Child[ren] Coverage	Employee & Child[ren] Coverage
$0.00	$3.57	$7.34	$3.77

Once an employee reaches five years of seniority, they are considered vested, and the cost for each dependent's coverage will reduce to match the employee's self-coverage premium costs.

VI. DENTAL COSTS

Administered through Delta Dental of Washington

Our contract requires all full-time employees, including those who waive out of medical insurance, to enroll in dental insurance. The Organization and our affiliates pay 100% of the premiums so there is no cost to employees who work at least 30 hours per week. Employees with less than five years of service pay 100% of premiums for their covered dependents. See the plan document for a full listing of covered services and benefits. *Continued on page 8.*

Dental Insurance, Monthly Costs - Non-Vested, Full-Time Employees			
Employee	Employee & Spouse Coverage	Employee, Spouse & Child[ren] Coverage	Employee & Child[ren] Coverage
$0.00	$52.64	$107.05	$54.40

Once an employee reaches five years of seniority, they are considered vested, and the cost for each dependent's coverage will reduce to match the employee's self-coverage premium costs.

VII. FLEXIBLE SPENDING ACCOUNT

Administered through Ameriflex

Flexible Spending Accounts (FSAs) allow employees who work at least 20 hours per week to set aside pre-tax dollars to pay for eligible expenses each year. This means your contributions will be deducted from your paycheck before your pay is taxed. You will not pay federal income or social security tax, and in most cases state income tax, on flexible spending account contributions. The Organization offers employees two different types of FSAs:

A. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A Health Care Flexible Spending Account (FSA) allows you to pay eligible health care expenses for yourself and your eligible dependents with tax-free dollars. Eligible expenses may include deductibles, copays, out-of-pocket vision or dental expenses, and prescribed over-the counter medications. The maximum eligible amount to contribute to your Health Care FSA is $3,300. Reimbursable claims may be incurred during January 1 through December 31 each year. You may submit claims for yourself and your eligible dependents until March 31 for claims incurred in the previous year.

Upon enrollment, you will be issued an FSA debit card loaded with your annual balance to pay for expenses directly. Alternatively, you can pay for your expenses out-of-pocket and submit the receipts for reimbursement. In both cases, you can administer your FSA account, request reimbursement, and upload your receipts by logging in to your Ameriflex account (https://participant.myameriflex.com/).

B. DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

A Dependent Care Assistance Program (DCAP) enables you to pay for work-related dependent care expenses with tax-free dollars. Eligible expenses may include daycare centers, in-home childcare and before/after school care. The IRS limitations for a DCAP allows individuals and jointly filing married couples to elect up to $5,000 annually, and you can elect up to $2,500 annually if married and filing separately.

C. ELIGIBILITY AND PLAN DETAILS

Employees who work at least 20 hours per week are eligible to participate in the Organization's medical reimbursement and dependent care assistance plans. You can enroll in the medical reimbursement and/or the dependent care reimbursement plan when you are first hired or during the annual open enrollment period each year. If you elect a deduction(s), you must continue it/them the entire year, unless you have a qualifying life event.

If you want to participate in either FSA option, you will need to re-enroll each year, during Open Enrollment. You will determine the amount you want to contribute annually. Contributions to your FSA are deducted from your paycheck in 24 equal amounts throughout the year before taxes are taken out.

Employees participating in the Medical FSA plan are eligible to rollover a maximum of $660 at the end of the 2024 plan year. Any funds remaining in the Medical FSA account beyond this cap will be forfeited. Employees participating in the Dependent Care Spending Account will not be able to rollover any funds not used within the plan year; these funds will be forfeited. If you wish to continue contributing to your account(s) from one year to the next, you must enroll again during the open enrollment period, or your deduction(s) will end on December 31.

Per our plan document, if you separate from employment your Health Flexible Spending Account will no longer be available for use for purchases after your termination date. All receipts for items purchased on or before your termination date plan must be submitted to Ameriflex within three months after your termination date in order to be processed fully for reimbursement. If you separate from employment your Dependent Care Assistance Program contribution payments made through payroll deduction will be available for use until the end of the plan year.

VIII. NON-MEDICAL INSURANCE

The following outlines all the non-medical insurance benefits available to Organization employees, both employer- and employee-paid. Employees are enrolled automatically in employer-paid benefits effective on their benefits eligibility date – the first of the month following date of hire. For employee-paid benefits, employees must enroll within 30 days of hire during the enrollment process, or 60 days after a qualifying life event.

To view specific coverage details and exclusions, please refer to the in-depth plan summaries on the SIMON benefits portal (simon365.com) or contact HR for assistance.

A. LIFE INSURANCE

Administered through Metropolitan Life Insurance Company (MetLife)

Life insurance protects your family from financial hardship in the event of your death. Full-time employees automatically receive basic life insurance coverage equivalent to two (2) times their annual rate of pay, up to a maximum of $300,000. Officers are eligible for coverage equivalent to

three (3) times their annual rate of pay, up to a maximum of $400,000. Employees may purchase additional Life Insurance for themselves and their eligible dependents. This benefit is provided at no cost to the employee.

B. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Administered through Metropolitan Life Insurance Company (MetLife)

Accidental Death and Dismemberment Insurance provides a benefit to you if you die or are injured as the result of an accident during business or pleasure. Full-time employees automatically receive basic AD&D Insurance coverage equal to two (2) times their annual salary, up to a maximum of $300,000. Officers are eligible for coverage equivalent to three (3) times their annual rate of pay, up to a maximum of $400,000. Please see the plan document for a full listing of benefit coverages. Like life insurance, employees may purchase additional AD&D Insurance for themselves and their eligible dependents. This benefit is provided at no cost to the employee.

C. LONG-TERM DISABILITY INSURANCE

Administered through Metropolitan Life Insurance Company (MetLife)

Long-term disability insurance covers a portion of your income when you have become injured or seriously ill. The Organization provides full-time employees with long-term disability insurance at no cost to the employee. After 90 days of disability, the plan will cover approximately 2/3 of basic monthly salary until the age of 65. The maximum monthly benefit is $8,000. Please see plan summary for details on coverage and exclusions. Employees may purchase short-term disability plans, as described below, as desired to fill the gap until long term disability is applied.

D. ADDITIONAL LIFE INSURANCE

Administered through USAble Life

All employees are eligible to purchase additional life insurance through USAble Life. Employees may select coverage from a minimum of $5,000 up to $300,000, with coverage levels increasing in $5,000 increments. Coverage over $100,00 requires evidence of insurability. Please see a table of rates below, based on age of the employee:

Monthly Rate Per $1,000 of Coverage					
Age	Life Rate	Age	Life Rate	Age	Life Rate
Under 30	$0.10	45-49	$0.42	65-69	$2.48
30-34	$0.11	50-54	$0.71	70-74	$4.35
35-39	$0.13	55-59	$1.22	75+	$6.65
40-44	$0.24	60-64	$1.41		

Premiums are assessed once per month through payroll deduction. An application for coverage is required for insurance levels of $100,000 and higher. Please contact HR for more info.

E. ADDITIONAL AD&D INSURANCE

Administered through AIG / Chartis Insurance

All employees are eligible to purchase additional AD&D insurance through AIG, including family benefits. To enroll, employees select a principal amount to be paid as a benefit in the event of an accident or death; cost is determined by the principal amount selected and whether the coverage is individual or family. Consult the table of rates to the right and see the plan summary for details. Application for coverage is required. Premiums are assessed once per month through payroll deduction. Please contact HR for more info.

Cost of Additional AD&D Insurance		
Class I	Monthly Cost	
Principal Sum	Individual Plan	Family Plan
$25,000	$2.00	$2.50
$50,000	$4.00	$5.00
$75,000	$6.00	$7.50
$100,000	$8.00	$10.00
$125,000	$10.00	$12.50
$150,000	$12.00	$15.00
$175,000*	$14.00	$17.50
$200,000*	$16.00	$20.00
$225,000*	$18.00	$22.50
Class II	Monthly Cost	
Principal Sum	Individual Plan	Family Plan
$25,000	$2.75	$3.75
$50,000	$5.50	$7.50
$75,000	$8.25	$11.25
$100,000	$11.00	$15.00

F. SUPPLEMENTAL INSURANCE COVERAGES

Administered through Aflac

The Organization offers various voluntary supplemental insurance plans through Aflac to all employees. Coverages through Aflac include accidental death and dismemberment (AD&D), short term disability, personal recovery, cancer care, dental, and life insurance. Enrollment is coordinated between HR and Aflac; please contact HR if you are interested in these benefits.

IX. RETIREMENT PLAN

Administered by Fidelity Investments

Upon hire, all regular employee over the age of 21 are automatically enrolled on the first of the month following hire with a deferral of 6% and are eligible to contribute up to fifty (50) percent of base annual pay to their retirement account, up to the federally approved maximum listed below. Retirement plan allocations can be changed at any time during the year. You may also change your monthly contribution at any time with Fidelity. The IRS limit for calendar year 2024 is:

- $23,500 General limit
- $7,500 Additional "catch-up" contribution amount if you are age 50 or older

The Organization and our affiliates match 100% of your contributions, up to a maximum of 6% of your base annual pay, made in regular contributions each pay period.

For each year of eligible service up to five (5) years, you own 20% of the match, plus earnings. "Eligible service" is defined as working at least 1,000 hours in a plan year. If you work fewer than 1,000 hours during a plan year, that year will not count as an eligible year of service toward vesting. After five years of service, you are 100% vested and own 100% of the employer match, plus earnings. If your employment ends before five years, you receive a share of the match based on your length of service; you forfeit the remaining share of the match.

X. ADDITIONAL BENEFITS

A. PAID TIME OFF BENEFITS

Eligible full-time and part-time employees receive a variety of paid time off benefits. Please refer to the SMCC Employee Handbook (03.2025) for details.

B. PAID HOLIDAYS

The organization observes the following paid holidays each calendar year:

New Year's Day - Jan. 1, 2025	Labor Day – Sep. 1, 2025
Martin Luther King, Jr. Day - Jan. 20, 2025	Veterans Day – Nov. 11, 2025
Presidents' Day - Feb. 17, 2025	Thanksgiving Day - Nov. 27, 2025
Memorial Day - May 26, 2025	Day after Thanksgiving - Nov. 28, 2025
Juneteenth - Jun. 19, 2025	Winter Office Closure - Dec. 25-31, 2025
Independence Day - Jul. 4, 2025	

The Organization closes at 3:00 p.m. before three-day weekends and at noon on the day before the Thanksgiving break and holiday closure. Employees of the organization are also eligible for one floating holiday per year.

C. PAID PARENTAL LEAVE

The Organization provides Paid Parental leave to eligible parent(s) upon the birth of a newborn child or a newly placed adopted or foster child. To be eligible, employees must have been employed by the Organization for at least 12 months and worked at least 1,250 hours during the 12-month period immediately preceding the beginning of leave. Eligible parent(s) will be credited with Paid Parental leave in the amount of 6 weeks, or 240 hours for full time employees, upon the birth or placement of the child. Leave will be pro-rated for part-time employees. Further, if both parents are employed by the Organization and eligible for leave, they may only receive a combined total of six weeks of leave for this purpose. Please see the Organization Employee Handbook, Section 6.9, for additional provisions.

D. COMMUNITY SERVICE LEAVE

The Community Service Leave Policy encourages sustained partnerships in the community and is designed to allow employees to voluntarily participate, with pay, in community service activities that occur during regularly scheduled work hours. Benefits eligible staff who work 30 hours per week or more will receive two (2) working days every calendar year to engage in service to the community throughout the year. Those benefits-eligible employees under 30 hours per week receive one (1) working day. These Community Service Leave hours do not accrue, do not count as hours worked for purposes of overtime, do not carry over into subsequent calendar years, and are not paid out upon separation from the Organization.

Full-time employees hired on or after July 1 receive one Community Service Leave-day to use the year they are hired; such time is prorated for part-time employees hired on or after July 1.

Please see the SMCC Employee Handbook (03.2025) for more details about this benefit.

E. TUITION REIMBURSEMENT

Employees may be eligible for tuition reimbursement after one year of continuous service. Affiliates have elected not to participate in this benefit. The pool of available funds is based on the Chamber's financial performance in the previous year. All requests must be submitted in writing and be formally approved by Chamber management. Tuition reimbursement is not guaranteed. See Section 9.6 of the Employee Handbook for additional details.

F. EMPLOYER-SUBSIDIZED ORCA TRANSIT CARD

The Organization subsidizes the cost of transit cards. All employees can participate in the ORCA pass program, which provides employees with an ORCA card that is pre-loaded with the region's Passport product.

G. EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered through Behavioral Health Systems

The Employee Assistance Program (EAP) is an organization-paid resource available to use any time you are experiencing personal or professional problems, including challenges surrounding child and elder care, parenting and legal/financial counseling. The purpose of the EAP is to help you or a family member identify and address your challenges in a confidential, non-threatening, effective, and positive way.

You can connect with the EAP service by calling (888) 720-5237 or at Behavioral Health Systems (behavioralhealthsystems.com).

H: OTHER BENEFITS & PERKS

Full-time employees are eligible to participate in the following additional benefits. See summaries at the end of packet.

- Woodland Park Zoo Discount
- SecureSave Workplace Savings Program with Optional $5 Semi-Monthly Employer Match
- Passport Corporate Discount Membership
- Pet Insurance
- BHT's Identity Protection plan with Norton LifeLock Benefit Solutions

XI. PLAN COMPARISON CHART

	Premera BlueCross				Kaiser
	Titanium 500 Prime Network		Sterling 750 Plus Heritage Network		Core HMO
	In-network	Out-of-network	In-network	Out-of-network	In-network
Annual Deductible					
Individual	$500	$1,000	$750	$1,500	None
Family	$1,000	$2,000	$2,250	$4,500	None
Out-Of-Pocket Maximums (includes deductible & co-pays) "OOP Max"					
Individual	$4,500	N/A	$6,000	Not applicable	$2,000
Family	$9,000	N/A	$14,300	Not applicable	$4,000
Preventive Care					
Well-baby exams	Covered in full	Not covered	Covered in full	Not covered	$20 co-pay
Adult physical exam	Covered in full	Not covered	Covered in full	Not covered	$20 co-pay
Well-women exams/ screenings	Covered in full	Not covered	Covered in full	Not covered	$20 co-pay
Immunizations	Covered in full	Not covered	Covered in full	Not covered	$20 co-pay
Professional Services					
Doctor office visit	$30 copay, applies to the OOP Max	$1,000 deductible, then 50% coinsurance	$35 copay, applies to the OOP Max	$1,500 deductible, then 50% coinsurance	$20 co-pay
Preventative Professional Diagnostic lab/X-ray	Covered in full	$1,000 deductible, then 50% coinsurance	Covered in full	$1,500 deductible, then 50% coinsurance	Inpatient: covered under hospital services Outpatient: covered in full
In-Patient Facility	$500 deductible, then 20% coinsurance	$1,000 deductible, then 50% coinsurance	$750 deductible, then 20% coinsurance	$1,500 deductible, then 50% coinsurance	$100 co-pay, per day for up to 3 days per admit
Out-Patient Facility	$500 deductible, then 20% coinsurance	$1,000 deductible, then 50% coinsurance	$750 deductible, then 20% coinsurance	$1,500 deductible, then 50% coinsurance	$20 co-pay
Urgent Care Center	$30 copay, applies to the OOP Max	$1,000 deductible, then 50% coinsurance	$35 copay, applies to the OOP Max	$1,500 deductible, then 50% coinsurance	$75 co-pay at designated facilities $75 co-pay at a non-designated facility
Emergency Room (co-pay waived if admitted)	$200 copay, in-network deductible, then 20% coinsurance	$200 copay, in-network deductible, then 20% coinsurance	$200 copay, in-network deductible, then 20% coinsurance	$200 copay, in-network deductible, then 20% coinsurance	$75 co-pay at designated facilities $125 co-pay at a non-designated facility
Mental Health Outpatient Professional Care	$30 copay, applies to the OOP Max	$1,000 deductible, then 50% coinsurance	$35 copay, applies to the OOP Max	$1,500 deductible, then 50% coinsurance	$20 copay
Prescription Drugs (Retail) - 30 Day Supply					
Generic	$10	$10 copay + 40% coinsurance	$10	$10 copay + 40% coinsurance	$15
Preferred Brand	$20	$20 copay + 40% coinsurance	$30	$30 copay + 40% coinsurance	$30
Non-Preferred Brand	$40	$40 copay + 40% coinsurance	$60	$60 copay + 40% coinsurance	N/A
Specialty	$250	Not Covered	$250	Not Covered	N/A
Prescription Drugs (Mail-Order) - 90 Day Supply					
Generic	$25	$25 copay + 40% coinsurance	$25	$25 copay + 40% coinsurance	$45
Preferred Brand	$50	$50 copay + 40% coinsurance	$75	$75 copay + 40% coinsurance	$90
Non-Preferred Brand	$100	$100 copay + 40% coinsurance	$150	$150 copay + 40% coinsurance	N/A
Specialty	$250	Not covered	$250	$250 copay + 40% coinsurance	N/A

**This summary is provided for general information only; please refer to the Summary of Benefits and Coverage available through Simon. Contact HR with any questions or concerns.*

XII. PART-TIME BENEFITS OVERVIEW

The below is a snapshot of Organization benefits available to part-time employees. Please see Benefits Brochure and Employee Handbook for full policies and details on all of the benefits outlined below.

A. MEDICAL/DENTAL/VISION INSURANCES

Part-time employees who work at least 20 hours per week but fewer than 30 hours per week can participate in our medical, dental, and vision plans. The cost for medical, dental, and vision coverage is as follows:

Health Insurance, Monthly Costs - Non-Vested, Part-Time Employees*						
Plan	Employee Coverage	Employee & Spouse Coverage	Employee, Spouse, & 1 Child Coverage	Employee, Spouse, & 2+ Children Coverage	Employee & 1 Child Coverage	Employee & 2+ Children Coverage
Kaiser Permanente	*See Premium Share Cost Chart Below*	+ $1,213.74	+ $1,831.64	+ $2,371.45	+ $617.88	+ $1,157.66
Premera Sterling Plus $750 - Heritage Network		+ $960.63	+ $1,729.15	+ $1,729.15	+ $768.52	+ $768.52
Premera Titanium Prime $500 - Prime Network		+ $980.79	+ $1,765.45	+ $1,765.45	+ $784.67	+ $784.67

Premium Share Cost	
If your annual earnings are:	**Your monthly premium share is:**
Up to $49,999	$0.00
$50,000 – $74,999	$20.00
$75,000 – $99,999	$30.00
$100,000-$124,999	$40.00
$125,000 and above	$50.00

Examples:

1. For an employee who makes $75,000 annually and has worked at the Organization for 2 years, the cost to cover themselves is $30 per month, regardless of which medical insurance plan they select. To add a dependent, they would pay the additional premiums listed above.
2. For an employee who makes $75,000 annually and has worked at the Organization for 6 years, the cost to cover themselves and two dependents is $90 per month ($30 x 3).

Premiums for you, your spouse, and dependent children are deducted on a pre-tax basis. Pre-tax means the deductions are taken from your gross pay before federal withholding and Social Security taxes are calculated and withheld.

Vision and Dental Insurance, Monthly Costs - Part Time Employees				
	Employee	Spouse	Spouse + Children	Children
Vision	$0.00	$3.57	$7.34	$3.77
Dental	$0.00	$52.64	$107.05	$54.40

B. NICE HEALTHCARE

NICE Healthcare is available to part-time employees and their dependents under 18 years old on Chamber Medical Insurance Plans. Nice Healthcare provides chat, video, and home primary care visits at a low or no cost. The service also includes primary care labs, x-ray imaging, prescriptions, physical therapy, mental health therapy, wellness, pregnancy, and chronic condition coaching.

C. NON-MEDICAL INSURANCES

The following benefits are not available for employees who work less than 30 hours per week:

- MetLife life insurance, long term disability insurance, and AD&D insurance coverage

The following benefits are available for employees who work 20 hours a week or more:

- Supplemental LifeMap life insurance, AIG/Chartis additional AD&D insurance, and all additional insurance coverages provided through Aflac.

D. FLEXIBLE SPENDING ACCOUNTS

All benefits-eligible staff can participate in the Flexible Spending Accounts & Dependent Care Accounts.

E. TIME OFF

All regular full-time and regular part-time employees are eligible for paid time off, holiday, and community service leave in accordance with Organization policies. Part-time employees earn holidays on a pro-rated basis, based on the number of hours worked.

F. OTHER BENEFITS & PERKS

Part-time employees are eligible to participate in the following additional benefits. See summaries at the end of packet.

- Organization sponsored retirement account and employer matching
- Employer-Subsidized ORCA Pass
- Woodland Park Zoo Discount
- SecureSave Workplace Savings Program with Optional $5 Semi-Monthly Employer Match
- Passport Corporate Discount Membership
- Pet Insurance
- BHT's Identity Protection plan with Norton LifeLock Benefit Solutions

XIII. MEDICAL PLAN & BENEFIT SUMMARIES

KAISER PERMANENTE CORE HMO

PREMERA TITANIUM 500 PRIME

PREMERA STERLING 750 PLUS

VISION SERVICE PLAN (VSP)

DELTA DENTAL

BEHAVIORAL HEALTH SYSTEMS EMPLOYEE ASSISTANCE PROGRAM (EAP)

PET INSURANCE

BHT IDENTITY PROTECTION PLAN

PASSPORT CORPORATE DISCOUNT MEMBERSHIP

WOODLAND PARK ZOO DISCOUNT

SECURESAVE WORKPLACE SAVINGS PROGRAM

NICE HEALTHCARE

Benefit Summary
Greater Seattle Chamber of Commerce
Group Number: 0396400

KAISER PERMANENTE®

Effective Date 1/1/2025	**Health Plan** Core HMO	**Ref** RQ-198324

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.

Kaiser Permanente believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Member Services (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S.Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform.

Benefits	**Inside Network**
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $4,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$20 copay
Hospital services	**Inpatient services:** $100 copay, per day for up to 3 days per admit **Outpatient surgery:** $20 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $15/$30 copay per 30 day supply
Prescription mail order	3 x prescription cost share per 90 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	CUSTOMIZED LANGUAGE

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:** Covered in full 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)	$75 copay at a designated facility $75 copay at a non designated facility
Hearing exams (routine)	$20 copay
Hearing hardware	Not covered
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 $20 copay
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** $20 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay
Newborn Services	Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	$20 copay CUSTOMIZED LANGUAGE
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** CUSTOMIZED LANGUAGE $100 copay, per day for up to 3 days per admit **Outpatient:** CUSTOMIZED LANGUAGE $20 copay
Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	**Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** CUSTOMIZED LANGUAGE **Outpatient Surgery:** See Hospital services; Outpatient surgery section
Temporomandibular Joint (TMJ) **services**	**Inpatient:** $100 copay, per day for up to 3 days per admit **Outpatient:** $20 copay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$20 copay
Optical hardware Lenses, including contact lenses and frames	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full

Premera Blue Cross : Prime Titanium 500

Coverage for: Individual or Family | **Plan Type:** PPO

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, call 1-800-722-1471 (TTY: 711) or visit us at www.premera.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 Individual / $1,000 Family. Out-of-network: $1,000 Individual / $2,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,500 Individual / $9,000 Family, Out-of-network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$30 copay/visit	50% coinsurance	None
	Specialist visit	$30 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (deductible does not apply)	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance (deductible does not apply)	50% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052147_2025.pdf	Generic drugs	$10 copay/prescription (retail), $25 copay/prescription (mail)	$10 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$20 copay/prescription (retail), $50 copay/prescription (mail)	$20 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	$40 copay/prescription (retail), $100 copay/prescription (mail)	$40 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	$250 copay/prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit + 20% coinsurance	$200 copay/visit + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: $200 copay/visit + 20% coinsurance Freestanding center: $30 copay/visit	Hospital-based: $200 copay/visit + 20% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay/visit Facility: 20% coinsurance (deductible does not apply)	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $30 copay/visit Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Habilitation services	Outpatient: $30 copay/visit Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 90 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	20% coinsurance	50% coinsurance	Limited to 240 respite hours - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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.)		
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations	• Hearing aids	

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: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 711. 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 www.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: your plan at 1-800-722-1471 or TTY 711, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

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	$500
Specialist copay	$30
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:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copay	$30
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:

Cost Sharing	
Deductibles	$30
Copayments	$1,100
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$30
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:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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

Premera Blue Cross : Prime Sterling 750

Coverage for: Individual or Family | **Plan Type:** PPO

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, call 1-800-722-1471 (TTY: 711) or visit us at www.premera.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $750 Individual / $2,250 Family. Out-of-network: $1,500 Individual / $4,500 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $6,000 Individual, $14,300 Family. Out-of-network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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 copay/visit	50% coinsurance	None
	Specialist visit	$35 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (deductible does not apply)	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance (deductible does not apply)	50% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/052147_2025.pdf	Generic drugs	$10 copay/prescription (retail), $25 copay/prescription (mail)	$10 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$30 copay/prescription (retail), $75 copay/prescription (mail)	$30 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	$60 copay/prescription (retail), $150 copay/prescription (mail)	$60 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	$250 copay/prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit + 20% coinsurance	$200 copay/visit + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: $200 copay/visit + 20% coinsurance Freestanding center: $35 copay/visit	Hospital-based: $200 copay/visit + 20% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 copay/visit Facility: 20% coinsurance (deductible does not apply)	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $35 copay/visit Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Habilitation services	Outpatient: $35 copay/visit Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 90 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	20% coinsurance	50% coinsurance	Limited to 240 respite hours - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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.)		
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations	• Hearing aids	

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: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 711. 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 www.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: your plan at 1-800-722-1471 or TTY 711, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

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	$750
Specialist copay	$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:

Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,220**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copay	$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:

Cost Sharing	
Deductibles	$30
Copayments	$1,300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,370**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copay	$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:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ຕະຫ ການບໍລິການ ຕະຫ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແລະບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
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A Look at Your VSP Vision Coverage

With VSP and BUSINESS HEALTH TRUST CHOICE PLAN B, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

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 which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 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®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

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.

More Ways to Save

Additional

$50

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

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

Your VSP Vision Benefits Summary

BUSINESS HEALTH TRUST CHOICE PLAN B and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$20	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • 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 doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME†	• $250 featured frame brands allowance • $250 Visionworks frame allowance on any frame • $200 frame allowance • 20% savings on the amount over your allowance • $110 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • UV protection • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
LIGHTCARE™+	• $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$25	Every 24 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to **vsp.com/framebrands** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

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		

†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.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP 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. TruHearing is not available directly from VSP in the states of California and Washington.

Classification: Restricted

DELTA DENTAL | Delta Dental of Washington

Business Health Trust

Business Health Trust – Plan 3

Group #09282

Delta Dental PPO℠ Plan

Benefit Summary

Benefit Period Maximum (Per Person)	$2,000
TMJ Annual Maximum (Per Person) Lifetime Maximum (Per Person)	50% $1,000 $5,000

	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)	**$0**	$0	$0
Class I – Diagnostic & Preventive Class 1 services do not apply towards your annual benefit period maximum!			
Exams Cleaning Fluoride X-Rays Sealants	**100%**	100%	100%
Class II – Restorative			
Fillings Endodontics (Root Canal) Periodontics Oral Surgery General Anesthesia/IV Sedation	**90%**	80%	80%
Class III – Major			
Dentures Partial Dentures Implants Bridges Crowns	**50%**	50%	50%

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

Business Health Trust

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 in to 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.

Have a question?

Give us a call at 800.554.1907, Monday – Friday from 7am to 5pm, Pacific Time. We're happy to help.

BEHAVIORAL HEALTH SYSTEMS

YOUR BHS BENEFITS

Caring for Your Mental Health

Mental health includes emotional, psychological and social well-being. *Self-care* can play a role in maintaining your mental health and help support your treatment and recovery if you have a mental illness. Self-care means taking the time to do things that help you live well and improve both your physical health and mental health. When it comes to your mental health, self-care can help you manage stress, lower your risk of illness and increase your energy. Here are some tips to help you get started:

- **Get regular exercise.** Just 30 minutes of walking every day can help boost your mood and improve your health.
- **Eat healthy, regular meals and stay hydrated.** A balanced diet and plenty of water can improve your energy and focus throughout the day.
- **Make sleep a priority.** Stick to a schedule, and make sure you're getting enough sleep.
- **Try a relaxing activity.** Explore relaxation or wellness programs or apps, which may incorporate meditation, muscle relaxation or breathing exercises.
- **Focus on positivity.** Identify and challenge your negative and unhelpful thoughts.
- **Stay connected.** Reach out to friends or family members who can provide emotional support and practical help.

BHS can help with the following issues:

- Stress Management
- Personal Relationships
- Marital/Family Issues
- Parent-Child Conflict
- Grief & Loss
- Coping After a Tragedy
- Depression & Anxiety
- Work-Related Problems
- Alcohol & Drug Abuse
- ADD/ADHD
- Life Transition
- Eating Disorders
- Financial/Legal

YOUR EAP BENEFIT

EAP sessions are free to employees and dependents and are completely confidential. To get started, call BHS at 888-720-5237 to be connected to your designated Care Coordinator. After an assessment you will be referred to the appropriate resources, which may include an appointment with a mental health professional, community resources, support groups, an attorney, and/or a financial consultant.

Self-care looks different for everyone, and it is important to find what you need and enjoy. It may take trial and error to discover what works best for you. In addition, although self-care is not a cure for mental illnesses, understanding what causes or triggers your mild symptoms and what coping techniques work for you can help manage your mental health.

When to Seek Professional Help:

Seek professional help if you are experiencing severe or distressing symptoms that have lasted two or more weeks, such as:

- Difficulty sleeping
- Appetite changes that result in unwanted weight changes
- Struggling to get out of bed in the morning because of mood
- Difficulty concentrating
- Loss of interest in things you usually find enjoyable
- Inability to perform usual daily functions and responsibilities

Don't wait until your symptoms are overwhelming. Call BHS at 888-720-5237 to discuss your concerns with your designated Care Coordinator.

Know Your Resources:

You can contact the following resources for additional support:

- National Suicide Prevention Lifeline: call 1-800-273-8255 or text 988
- National Alliance on Mental Illness (NAMI) Hotline: call 1-800-950-6264
- National Alliance on Mental Illness (NAMI): text HOME to 741741
- Substance Abuse & Mental Health Services Administration (SAMHSA): call 1-800-662-4357
- National Domestic Violence Hotline: call 1-800-799-7233 or 1-800-787-3224

Access Your Benefits:

Accessing your Employee Assistance Program (EAP) has never been easier! Call 888-720-5237 or visit www.behavioralhealthsystems.com to learn more about your benefits and schedule a free, confidential visit with a mental health professional.

Telehealth
Available via phone
or web-based

In-Person
With a doctor,
counselor or advisor

Digital
Access to
Virtual solutions

BHS®
BEHAVIORAL HEALTH SYSTEMS
Behavioral Healthcare Programs for Business & Industry Since 1989

Your pet insurance benefit

Business Health Trust is excited to offer pet health insurance for your dog or cat at a discount!

petpartners

Business Health Trust

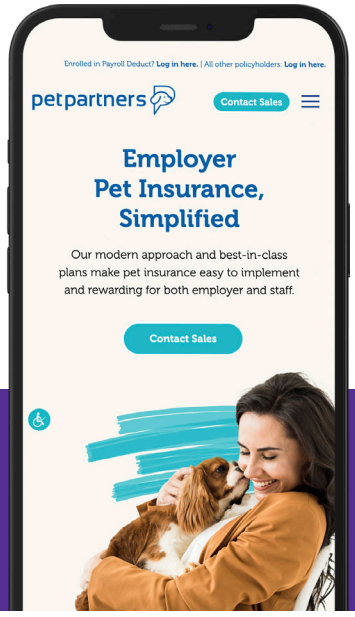
What is pet insurance?

Pet insurance is health insurance for dogs and cats. Get reimbursed for costly veterinary bills and focus more on the health of your pets and less on how you're going to pay for it. Plans feature comprehensive coverage for accidents, illnesses and injuries including cancer coverage.

How it works

1. Enroll in pet insurance.
2. Pay your vet.
3. Submit a claim with your vet bill.
4. Get reimbursed for eligible expenses.

Scan to begin



Questions? Need help enrolling? Contact us:

866-774-1113 help@petpartners.com

Protect your digital health too

Norton LifeLock Benefit Solutions and Business Health Trust are proud to offer identity theft protection to our members.

norton™ Benefit Solutions

Business Health Trust

Comprehensive protection features to help you feel safer in your digital life

Device Security protects your mobile devices, tablets, and computers from hackers, viruses, malware, vulnerable websites, and other online threats.

Identity Alerts with Credit monitoring alerts you if there is fraudulent or suspicious activity surrounding any of your personal information, including new account opening, credit card usage, and data breaches.

Social Media Monitoring notifies you of any suspicious links, account takeover attempts, or inappropriate content.

Norton™ Secure VPN Our Virtual Private Network (VPN) helps protect your online privacy so your sensitive information, browsing history, online activities and webcam are more secure.

Parental Control makes it easy to monitor your child's online activities and view their search history so they stay safe.

Million Dollar Protection™ Package to reimburse stolen funds, personal expenses, and provide coverage for lawyers and experts up to $1 million each.

Questions? Contact us:

(425) 201-1972

info@businesshealthtrust.com

Employees will be auto-enrolled 1/1/2024 and can enroll dependents or family members at no cost at their discretion

Make the most of your benefits

Cost Savings with Passport Corporate

Business Health Trust

PASSPORT® CORPORATE

What's covered—highlights

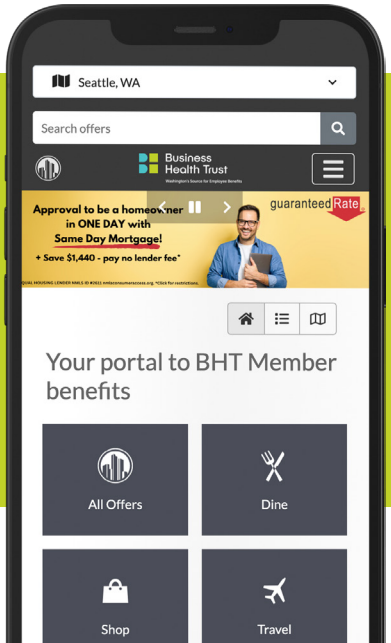
- Complimentary access for all Business Health Trust members and accredited producers.
- Discounts on 2500+ vendors—including pet insurance, travel, entertainment, shopping, local restaurants and more!
- Enjoy exclusive savings without any additional cost or fees.

DINE, SHOP, TRAVEL AND SAVE!

Saving just got easier with your complimentary Passport membership from BHT.

"30% off my recent stay at Great Wolf Lodge"

"10% off my laptop purchase from Dell"



Scan the QR code to get started:

Where to start

1. Visit **www.passportcorporate.com**
2. Register with your at-work email to sign-up (i.e. name@yourwork.com)
3. Download the **"PASSPORT MOBILE"** app on your smartphone and sign in with your new mobile card.

Contact **savings@businesshealthtrust.com** if you experience any difficulties enrolling.

www.businesshealthtrust.com

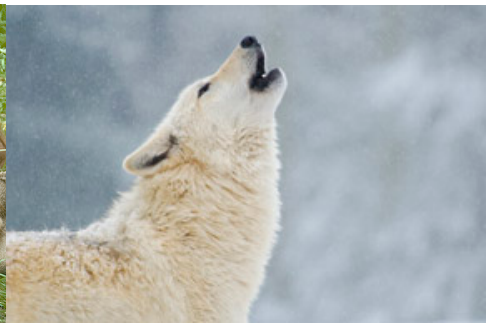
Woodland Park Zoo
Discount Ticket Program for staff of: Seattle Metropolitan Chamber of Commerce

Purchase discount zoo tickets online and avoid the ticket line at Woodland Park Zoo!

HOW IT WORKS:

- Visit **www.zoo.org**
- Click the blue **Ticket**s button on the top of the page
- Click on **Buy** in the **General Admission** box
- Enter Promo Code **seattlechamber18** when prompted to receive a 20% discount
- Purchase tickets and print at home or provide on your mobile device!





SecureSave

At-a-glance

SecureSave is an Emergency Savings Account (ESA). We help you automatically save directly from your paycheck – you decide how much and can stop at any time.

SEATTLE METRO CHAMBER'S PROGRAM

$5

$5 match each paycheck

When you save $5 or more

THE CHAMBER

seattle metropolitan chamber of commerce

WHAT TO KNOW

- ✓ This benefit is sponsored by Seattle Metro Chamber and completely free to you
- ✓ You can access your funds anytime for any reason at no cost
- ✓ The account and money are always yours (even if change in employment)
- ✓ The account is FDIC insured up to $250,000
- ✓ There are no account minimums
- ✓ Funds in SecureSave are all post-tax

WHAT HAPPENS IN AN EMERGENCY

To access your emergency savings, you will need to have a personal bank account linked.

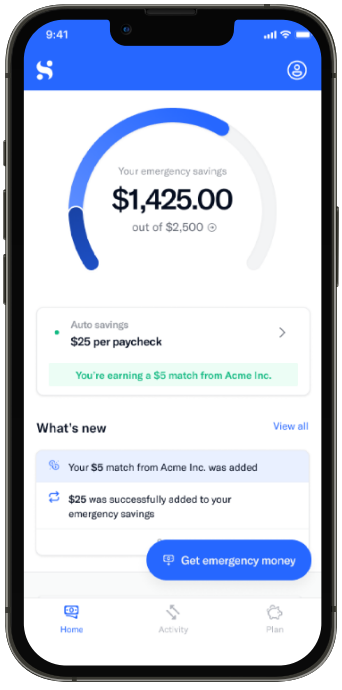
Flip over to learn how to get started

Sign up in just 2 minutes!

You will receive an invitation via email and/or text message from SecureSave Just click on the link and follow the prompts.

WHAT TO EXPECT

- Accept invitation via email or text
- Choose your savings amount
- Link a bank account (optional)
- Watch your savings grow each paycheck with help from Seattle Metro Chamber



NEED HELP?

SecureSave

support.securesave.com
206-666-4900
support@securesave.com

nice

Healthcare That's Nice

Our mission is simple

make getting amazing everyday care easy and affordable

> "They were so personable and made me feel as comfortable as possible, and really made time to learn about me and my health issues. I highly recommend Nice.
>
> **Angela K.**
> Nice Healthcare Patient

The Nicest Benefit

These are the **free** integrated primary care services that Nice Healthcare® offers with no out-of-pocket fees:

- Virtual Chat and Video Visits
- In-Home Visits with 35 Free Labs and Physical Tests
- 550+ Free Medications Can Be Prescribed by Our Clinicians
- Virtual Physical Therapy Visits
- Virtual Mental Health Therapy Visits
- In-Home X-rays and EKG Services

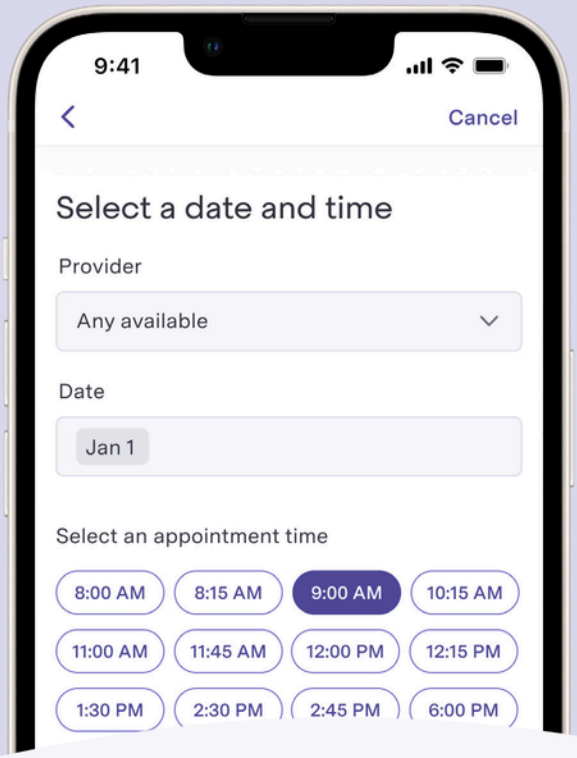
Visit **nice.healthcare**

*You may incur a small visit fee if you are enrolled in a High Deductible Health Plan (HDHP). Please confirm with your employer for further details.

It All Starts With The Nice App

Whenever you and your dependents need Nice, you'll begin the process by scheduling a virtual visit with a clinician. All virtual services are conducted using the Nice app, including chat and video visits, physical therapy and mental health therapy.

In addition to scheduling and conducting visits, you will also use the Nice app to review treatment plans, upload documents and manage your accounts.



The Clinic That Comes To You

We offer our clinician services in parts of Arizona, Colorado, Idaho, Iowa, Minnesota, Nebraska, Nevada, New Mexico, Oregon, Utah, Washington, and Wisconsin.

- Virtual Only
- Virtual & In-Home

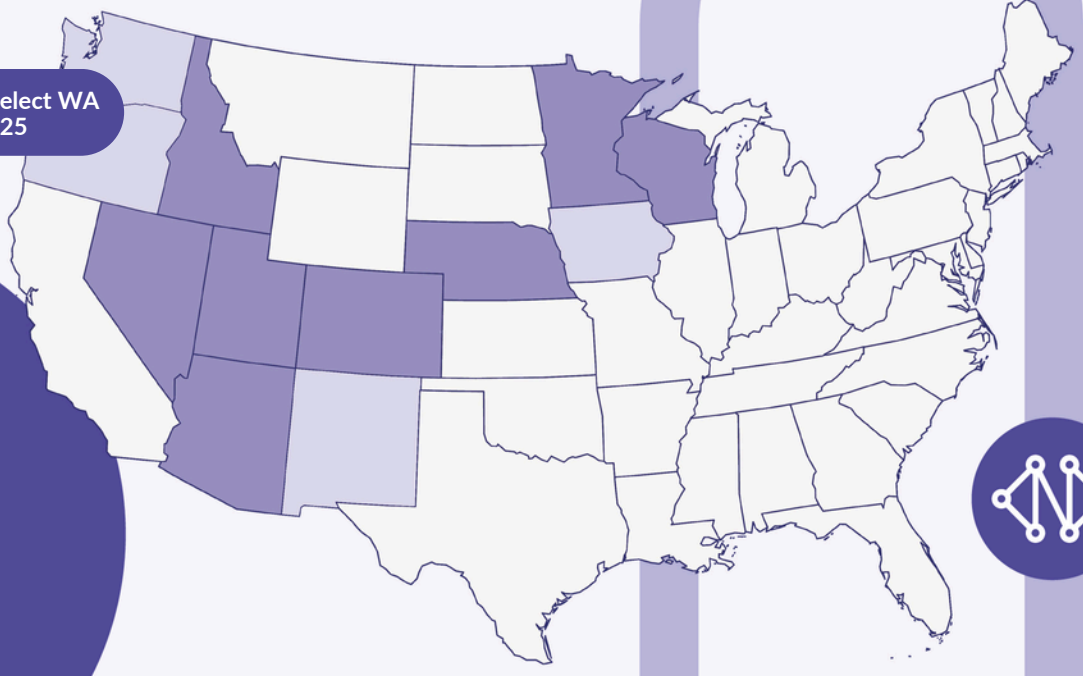
In-Home available in select WA areas in July 2025

Online Visit Hours

mon - fri	8am - 7pm CT
sat - sun	9am - 12pm CT
mon - fri	7am - 6pm MT
sat - sun	8am - 11am MT
mon - fri	6am - 5pm PT
sat - sun	7am - 10am PT

Home Visit Hours (local time)

mon - fri 9am - 5pm



Download the app

When to Use Nice®

EVERYDAY CARE WHENEVER YOU NEED IT

Routine Checkups

Annual Wellness Exam - Sports Physicals - Child Checkups

Chronic Care

High Blood Pressure - High Cholesterol - Thyroid Conditions - Diabetes

Sick Care

Cold/Flu - Strep Throat - Sinus & Ear Infection - UTIs - Pink Eye - Rashes

Short-Term Mental Health

Anxiety - Depression - Grief & Loss

Virtual Physical Therapy

Back Pain - Neck Pain - Injury Recovery

Imaging

X-Rays - EKGs

35+ Labs

Blood Work - A1c

> **They were so personable and made me feel as comfortable as possible, and really made time to learn about me and my health issues. I highly recommend Nice.**

Angela K.
Nice Healthcare Patient

All this care and more!

Download the app to get started.

It All Starts With the App

Use the Nice app to schedule visits, chat with clinicians, attend video visits, review treatment plans, upload documents, and more.

Create Your Account

Open the app and select “Sign Up”. Using your personal email address, fill out the required fields.

Sign Into Your Account

Open the app and select “Log In”. Enter your email and password and you’ll be taken to your homepage.

Add Dependents (if necessary)

On the homepage, click the “Accounts” button and select “Add Patient” on the bottom of the next screen. Fill out the necessary information and repeat for each dependent.

Complete the Intake Form

On the homepage, click the “Book Appointment” button. Select the patients and complete the Intake form*.

***This process will take 15-20 minutes, but only needs to be completed before your first visit. Schedule future visits in under 5 minutes.**

Schedule Your First Visit

On the next screen, choose the appointment type (video or chat), preferred provider (if any), preferred date and time slot. Complete the remaining steps and you’ll see your appointment on your homepage.

nice

Mental Health Therapy

SHORT-TERM MENTAL HEALTH SUPPORT

At Nice Healthcare®, we emphasize the need to address both mental and physical health to enhance your day-to-day life. Mental health treatment through Nice empowers you to maintain your mental wellness.

Nice offers the flexibility of up to 8 sessions to support you in developing the skills and mindset to take charge of your thoughts, feelings, and behaviors.

You can schedule a mental health assessment by selecting Mental Health Therapy when prompted with “How can we help?” while filling out the intake form in the Nice app or online.

You may be guided to external resources that can better support your mental health needs during the intake process or after your assessment.

Who’s eligible?

- Must be at least 18 years old
- Must not already be in therapy

Nice can help patients:

- Enhance mindfulness
- Navigate parenthood or other life transitions
- Increase confidence in managing social situations
- Improve stress management
- Develop boundary setting skills
- Strengthen conflict resolution skills
- Refine their ability to regulate emotions
- Live in better alignment with their values
- Communicate more effectively in relationships

Nice does not prescribe controlled substances or antipsychotic medications, and does not provide evaluations for ADHD, ASD, or other disorders.

Mental health treatment through Nice is **not intended** to address serious mental illness or chronic mental health needs, such as (but not limited to):

- Severe mood dysregulation
- Suicidal/homicidal ideation
- Self-injurious behavior
- Substance use
- Complicated grief
- Eating disorders
- Psychosis
- Trauma

We recognize the value of long-term therapy and other mental health service types to address these needs.

nice

If you have any questions about mental health treatment through Nice, please contact your designated Nice representative.

VISIT NICE.HEALTHCARE

Nice Rx

THE NICE PHARMACY PROGRAM

Nice clinicians can help you manage your medications and write new ones for you. Nice covers 550+ of the most common medications which can be prescribed with no out-of-pocket costs for patients.

1. **Schedule a chat or video visit in your Nice Healthcare® app.** Your clinician will determine if you need a prescription and send the order to your preferred pharmacy.
2. **Pick up your prescription at one of Nice's 60,000 in-network pharmacies, excluding Walgreens.** Your prescription will be waiting when you arrive. Show your Nice Rx card, printed or in the app, and check out. You will have to use your health insurance, or pay in cash, for any non-covered medications.

Types of Medications

- Allergy/Sinus
- Antibiotics
- Anti-Fungal
- Anti-Viral
- Asthma
- Cold/Cough
- Diabetes
- Ear/Eye Drops
- Gastrointestinal
- High Cholesterol
- Hypertension
- Mental Health
- Skin
- Thyroid
- Women's Health

Physical Therapy

IMPROVE MOBILITY • REDUCE PAIN • RESTORE FUNCTION

Take the first steps to a healthier, more active lifestyle with our support at Nice. In our physical therapy sessions, teamwork is key, and you're the star player. Our skilled team of physical therapists is dedicated to guiding you through this journey.

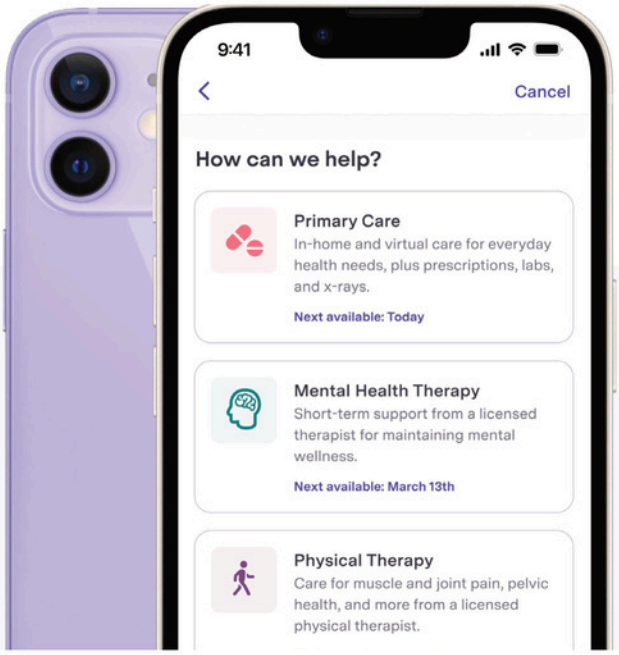
Nice's physical therapy service can help you:

- Enhance your mobility and movement.
- Alleviate discomfort and address pain.
- Restore your full range of strength and function.
- Provide strategies to prevent future injuries.

Our therapists collaborate closely with you to craft a personalized plan to meet your specific goals and requirements. If needed, you'll recieve a resistance band and mobile app to guide you through your exercises between check-ins.

We emphasize understanding the reasoning behind our treatments, working in coordination with your primary care and mental health clinicians.

Schedule a physical therapy visit simply by selecting Physical Therapy when prompted with "How can we help?" when filling out the intake form.



How do I get started?

Sign into the app. You can download the app using the QR code or by searching for "Nice Healthcare" in your app store.