EMPLOYEE BENEFIT SUMMARY

PREPARED FOR THE EMPLOYEES OF

JOHNSTON ARCHITECTS PLLC JA

Employee Manual

EFFECTIVE:
Medical: October 1, 2016
Dental: April 1, 2017

Presented by:
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TO: ALL BENEFIT ELIGIBLE EMPLOYEES OF JOHNSTON ARCHITECTS

Welcome to the annual employee benefits anniversary of our group insurance program. Please use this manual for your reference for our Medical and Dental policies. We are happy to announce that Benefit Design Services will continue to be our insurance broker. If you have any questions regarding our insurance plans they would be happy to assist you.

*If you have **not** received your ID card(s), we recommend that you contact the carrier to confirm your coverage is in effect.

KEY CONTACTS:

BENEFIT DESIGN SERVICES

Customer Service (425) 712-8244

Or if you wish to contact the Insurance Carrier direct please call:

MEDICAL:

- **Group Health** **Group# 0006500**

  Web Address www.ghc.org
  Customer Service (888) 901-4636

DENTAL:

- **Delta Dental** **Group# 08405**

  Web Address www.deltadentalwa.com
  Customer Service (800) 554-1907

GroupHealth

Group Health Cooperative: VisitsPlus Gold

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2016 to 1/1/2017
Coverage for: Group | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ghc.org or by calling 1-888-901-4636.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual/**$1,000** family Does not apply to preventive care, prescription drugs, hospice, pediatric eye exam and glasses.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$4,500** individual/**$9,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.ghc.org or call 1-888-901-4636 for a list of Group Health/Core in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. See www.ghc.org or call 1-888-901-4636 for a list of specialist providers.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	Not covered	Deductible does not apply
	Specialist visit	$30 copay	Not covered	Deductible does not apply
	Other practitioner office visit	$10 primary / $30 specialty copay for manipulative therapy, naturopathy and acupuncture	Not covered	Deductible does not apply Manipulative therapy limited to 10 visits per calendar year and acupuncture limited to 12 visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	Deductible does not apply. Services must be listed in accordance with the Group Health well-care schedule.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	_____none_____
	Imaging (CAT/PET scans, MRIs)	20% coinsurance	Not covered	High end radiology imaging services such as CAT, MRI and PET require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug**	Preferred generic drugs	$10 copay	Not covered	Deductible does not apply Covers up to a 30-day supply
	Preferred brand drugs	$30 copay	Not covered	Deductible does not apply Covers up to a 30-day supply
	Specialty drugs	40% coinsurance	Not covered	Deductible does not apply Covers up to a 30-day supply

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
coverage is available at www.ghc.org/formHIM6T	Mail-order drugs	Preferred generic $5 copay, preferred brand $25 copay, 40% coinsurance specialty	Not covered	Deductible does not apply Covers up to a 90-day supply. Specialty drugs covered up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	_____none_____
	Physician/surgeon fees	20% coinsurance	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	$200 copay + 20% coinsurance	$200 copay + 20% coinsurance	Notify Group Health within 24 hours of admission, or as soon thereafter as medically possible. Copay is waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____
	Urgent care	$10 primary / $30 specialty copay	$200 copay +20% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Non-emergency inpatient services require preauthorization.
	Physician/surgeon fee	20% coinsurance	Not covered	Non-emergency inpatient services require preauthorization.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 primary / $30 specialty copay	Not covered	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	Non-emergency inpatient services require preauthorization.
	Substance use disorder outpatient services	$10 primary / $30 specialty copay	Not covered	_____none_____
	Substance use disorder inpatient services	20% coinsurance	Not covered	Non-emergency inpatient services require preauthorization.
If you are pregnant	Prenatal and postnatal care	$10 primary / $30 specialty copay	Not covered	Preventive services related to prenatal and preconception care are covered as preventive care. Routine prenatal and postnatal care is not subject to the deductible and copay.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	Not covered	Notify Group Health within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 130 visits per calendar year. Requires preauthorization.
	Rehabilitation services	$30 specialty copay / outpatient 20% coinsurance / inpatient	Not covered	Limited to 25 visits per calendar year/outpatient. Limited to 30 days per calendar year/inpatient. Inpatient services require preauthorization.
	Habilitation services	$30 specialty copay / outpatient 20% coinsurance / inpatient	Not covered	Limited to 25 visits per calendar year/outpatient. Limited to 30 days per calendar year/inpatient. Inpatient services require preauthorization.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 60 days per calendar year. Requires preauthorization.
	Durable medical equipment	20% coinsurance	Not covered	_____none_____
	Hospice service	No charge	Not covered	Deductible does not apply. Requires preauthorization.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Deductible does not apply. Limited to one exam per calendar year.
	Glasses	No charge	Not covered	Deductible does not apply. Limited to 1 pair of frames and lenses or contact lenses per year.
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.ghc.org
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care (if prescribed for rehabilitation purposes)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-901-4636. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Washington Office of Insurance Commissioner at http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: http://www.insurance.wa.gov/your-insurance/email-us/. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,020
- **Patient pays** $2,520

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,020
- **Patient pays** $1,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$700
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SMALL BUSINESS GROUP

GroupHealth®

2016 VisitsPlus Gold Core provider network

The VisitsPlus Gold plan is weighted in favor of low cost shares when care is received for the cost of a higher premium. This plan provides unlimited office visits prior to the deductible and features the Core network, which offers access to specially selected providers for the greatest value.

CALENDAR COSTS

Annual deductible	$500 Member / $1,000 Family
Member coinsurance	20%
Out-of-pocket maximum	$4,500 Member / $9,000 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture—12 visits PCY Manipulative therapy—10 visits PCY Adult vision exam—1 exam PCY; Hardware: $100 allowance ◆	**Unlimited office visits prior to deductible** $10 Primary ◆ / $30 Specialty ◆
Prescription drugs Costs per 30-day supply	Generic: $10 ◆ Brand: $30 ◆ Specialty: 40% ◆
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply except specialty	Generic: $5 ◆ Brand: $25 ◆ Specialty: 40% ◆
Urgent care at designated urgent care center	$10 Primary ◆
Hospitalization	20%
Emergency services	$200 + 20%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient/outpatient surgery	Covered in full ◆ 20%
Laboratory and radiology services	20%
Rehabilitative and habilitative services Inpatient rehabilitation—30 days PCY Outpatient rehabilitation—25 visits PCY DME (durable medical equipment), including prosthetics	20% $30 Specialty ◆ 20%
Ambulatory outpatient services	20%
Pediatric vision Covered for members up to age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

For more information, including premium rates, visit **ghc.org/sbg**.

PRIMARY CARE (LOWER IN-NETWORK COPAY)
These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER IN-NETWORK COPAY)
These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

*Nutrition counseling may be covered as preventive when certain requirements are met.

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

Coverage is provided by Group Health Cooperative

◆ Deductible does not apply | PCY = Per calendar year

SMALL BUSINESS GROUP

GroupHealth®

2016 Pediatric dental coverage

Dental coverage is a federally mandated benefit for members up to age 19. When you select a new 2016 Group Health medical plan, it will be paired with the pediatric dental plan that is offered by Delta Dental of Washington unless you select one of the Delta Dental family plans that include this coverage. Here is a summary of Delta Dental's pediatric dental plan benefits.

	Delta Dental participating dentist	Non-participating dentist
Annual maximum	Unlimited	
Annual deductible Waived on Class I benefits	$50 / member	
Annual out-of-pocket maximum	$350 / member; $700 / family	Not applicable
Diagnostic and preventive Exams, prophylaxis, fluoride, X-rays, sealants	100%	100%
Restorative Restorations (includes posterior composites), endodontics, periodontics, oral surgery*	50%	50%
Major Crowns*, dentures, partials, bridges	50%	50%
Orthodontia (medically necessary)* Coinsurance Lifetime maximum	50% Unlimited	

* Requires preauthorization

Monthly rate

The cost to employers for this dental coverage for members under age 19 is billed only for the first three members in any one family.

1 member	$37.08
2 members	$74.16
3+ members	$111.24

DELTA DENTAL®

Delta Dental of Washington

Rates and plan are subject to Office of the Insurance Commissioner (OIC) approval.

Continued next page

FINDING A PARTICIPATING DENTIST

These plans allow you to choose dentists from two networks: Delta Dental PPO or Delta Dental Premier. You can find a participating, in-network dentist in your area by visiting **deltadentalwa.com** and using the "Find a Dentist" tool.

THE ADVANTAGES OF SEEING A DELTA DENTAL PPO OR DELTA DENTAL PREMIER DENTIST

We encourage you to see a Delta Dental of Washington network dentist because they provide treatments at discounted rates and file all claims paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance, or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of-pocket savings if you choose a dentist from the Delta Dental PPO network.

ABOUT USING IN-NETWORK AND OUT-OF-NETWORK DENTISTS

When visiting an in-network dentist, be sure to mention that you're covered by Delta Dental of Washington and give them your member identification number, plan name, and group number.

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible for having the dentist complete your claim forms and to ensure that the claims are submitted to Delta Dental. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after Delta Dental pays. Unlike participating dentists, Delta Dental has no control over non-participating dentists' charges or billing procedures.

QUESTIONS?

Call Delta Dental of Washington at 1-800-554-1907, Monday–Friday, 8 a.m.–5 p.m. or go online to **deltadentalwa.com** for answers.

15-SBG-1106-04 2015-08

DELTA DENTAL® Delta Dental of Washington

Information Page

Group # 09142-11100 - JOHNSTON ARCHITECTS

Plan Name: Delta Dental PPO and Delta Dental Premier – Basic Pediatric Plan (QDP)

Plan Information	
Contract Term:	The effective date of this Contract shall be 12:01 a.m. Pacific Time on the first day of October, 2016 at Seattle, Washington and shall run for a period of 12 months. The Contract Term for this contract shall be the period beginning October 01, 2016 through September 30, 2017
Benefit Period:	Benefit Period mean the period beginning the first day of October, 2016 and ending the last day of December, 2016.
Waiting Period:	No Waiting Period
Minimum Group Size:	There is no minimum group size requirement
Plan Deductible	$50 per child per year
Annual Benefits Maximum:	There is no annual maximum
Annual Out-of-Pocket Maximum	$350 per child per year, up to $700 for families with two or more children, for services received from a Delta Dental PPO or Delta Dental Premier Dentist *Note: Out-of-Pocket Maximum does not apply to services performed by Non-Participating Dentists*

Covered Dental Benefit	**Amount of Maximum Allowable Fee DDWA Pays:**	
	Participating Providers (Delta Dental PPO or Delta Dental Premier Dentists)	**Non-Participating Dentists****
Diagnostic Services*	100 percent	100 percent
Preventive Services*	100 percent	100 percent
Adjunctive General Services	50 percent	50 percent
Simple Restorative Services	50 percent	50 percent
Oral Surgery	50 percent	50 percent
Crowns	50 percent	50 percent
Periodontics	50 percent	50 percent
Endodontics	50 percent	50 percent
Removable Prosthetics	50 percent	50 percent
Medically Necessary Orthodontia*	50 percent	50 percent
Accidental Injury*	100 percent	100 percent

* Deductible waived for these benefits

** DDWA has no control over the charges or billing practices of Non-Participating Dentists. Payment for services performed by a Non-Participating Dentist will be based on actual charges or DDWA

Monthly Billable Amount*	One Child	$ 37.08
	Two Children	$ 74.16
	Three or More Children	$ 111.24

* The Billable Monthly Amount represents the total amount that will be billed per subscriber.

Delta Dental of Washington

JOHNSTON ARCHITECTS

Group # 09142-11100

Summary of Benefits

Delta Dental PPO and Delta Dental Premier – Basic Pediatric Plan (QDP)

Effective October 01, 2016, the following benefit information applies to your plan.

Reimbursement Levels for Allowable Benefits

Covered Dental Benefit	Amount of Maximum Allowable Fee DDWA Pays:	
	Participating Providers (Delta Dental PPO or Delta Dental Premier Dentists)	**Non-Participating Dentists****
Diagnostic Services*	100 percent	100 percent
Preventive Services*	100 percent	100 percent
Adjunctive General Services	50 percent	50 percent
Simple Restorative Services	50 percent	50 percent
Oral Surgery	50 percent	50 percent
Crowns	50 percent	50 percent
Periodontics	50 percent	50 percent
Endodontics	50 percent	50 percent
Removable Prosthetics	50 percent	50 percent
Medically Necessary Orthodontia*	50 percent	50 percent
Accidental Injury*	100 percent	100 percent

* Deductible waived for these benefits

** DDWA has no control over the charges or billing practices of Non-Participating Dentists. Payment for services performed by a Non-Participating Dentist will be based on actual charges or DDWA

Benefit Period

Most dental benefits are calculated within a 'benefit period', which is typically for one year. For this Plan, the benefit period is the 12-month period beginning January 1 and ending December 31.

Delta Dental of Washington

Group Number: **09142-11100**
Group Name: **JOHNSTON ARCHITECTS**

This card is for identification only and is not a guarantee of coverage. For benefits information, visit us at www.DeltaDentalWA.com

Delta Dental of Washington

Plan Deductible

Annual Deductible per Child $50

Your plan has a $50 deductible per eligible child each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of $50 is made. Once each eligible child has satisfied the deductible during the period, no further deduction will apply to that person until the next period. The deductible does not apply to Diagnostic Services, Preventive Services, Medically Necessary Orthodontia, or Accidental Injury.

Plan Maximum

There is no annual Plan Maximum for your Plan.

Maximum Out-of-Pocket

Individual $350

Family with 2 or more children..... $700

Services performed by a Non-Participating Dentist do not accrue towards the Out-of-Pocket maximum.

Orthodontic Maximum

There is no maximum for covered, medically necessary orthodontic treatment.

Delta Dental of Washington Information Card

The information card contains important information that should be given to your dentist when you or your eligible dependent receive treatment. At the time of treatment, please provide your name, the information on this card, and your member identification number to your dental office so that they office can submit your claim to Delta Dental of Washington. This information card is not proof of coverage. Please refer to your dental benefit booklet for specific eligibility and coverage information.

Customer Service - 800-526-8323

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

DELTA DENTAL® Delta Dental of Washington

Johnston Architects
Group #08405

Delta Dental PPO℠ Plan
Benefit Summary

Effective Date	April 1, 2017
Benefit Period	January 1, 2017 – December 31, 2017
Benefit Period Deductible Per Person/Per Family Waived on Class I Services	$50/$150
Benefit Period Maximum Per Person Class I Services do not apply toward benefit period maximum	$2,000
TMJ Annual maximum Lifetime maximum	50% $1,000 $5,000
Orthodontia Adults and Dependent children Lifetime maximum per person	Not Available

	Dental Network			
	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist	Out-of-State (Out-of-Service Area) Dentist
Class I – Diagnostic & Preventive				
Exams, Cleanings, X-rays, Fluoride and Sealants	**100%**	100%	100%	100%
Class II – Restorative				
Fillings and Posterior Composites, Oral Surgery, Root Canals, Endodontics and Periodontics	**90%**	80%	80%	90%
Class III – Major				
Crowns, Dentures, Partial Dentures, Implants and Bridges	**50%**	50%	50%	50%

Please Note: This is a brief summary of available benefits for comparison purposes only and does not constitute a contract. Once enrolled in a plan, you will have access to your benefits booklet which provides more details of your Delta Dental PPO Plan. Please feel free to call our customer service department or visit our website at **DeltaDentalWA.com** if you have any questions.

You will likely experience the greatest out-of-pocket savings when you see a Delta Dental PPO dentist.

PPO 2017

Here's some important information to help you use your benefits:

Finding a participating dentist

You can choose dentists from two nationwide networks: Delta Dental PPO℠ or Delta Dental Premier®. Find a participating, in-network, dentist in any state by visiting DeltaDentalWA.com and using our Find a Dentist tool. We recommend you select the Delta Dental PPO network to filter your search results.

The advantages of seeing a Delta Dental PPO or Delta Dental Premier dentist

We encourage you to see a Delta Dental network dentist because they provide services at discounted rates and file all claims paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of pocket savings if you choose a dentist from the Delta Dental PPO network.

Visiting your participating, in-network, dentist

Be sure to tell your dentist you're covered by Delta Dental of Washington and give them your member identification number, plan name and group number.

Visiting a non-participating, out-of-network, dentist

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible to have the dentist complete your claim forms and to ensure that the claims are sent to us. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after we pay. Unlike our participating dentists, we have no control over non-participating dentists' charges or billing procedures.

Visiting an out-of-state (out-of-service area) dentist

If you or a dependent live outside of Washington State, you may visit any licensed dentist. When you visit a dentist who participates in any Delta Dental network they'll handle all claims paperwork. If you visit a dentist who does not participate, you'll be responsible to have the dentist complete your claim forms and ensure the claims are sent to us. Claim payments will be based on actual charges or our maximum allowable fees for participating dentists, whichever is less.

Confirmation of Treatment and Cost (Formerly called Predeterminations)

When your dentist recommends treatment, we encourage you to ask them to submit a Predetermination. Once submitted, you'll receive a Confirmation of Treatment and Costs (Confirmation). A Confirmation details your dentist's specific treatment plan, what your benefits pay, and gives you an accurate out-of-pocket estimate.

Have a question?

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