<table>
<thead>
<tr>
<th>Benefit Plans</th>
<th>Kaiser Network</th>
<th>Delta Dental (Model PPO) (Available to Full-Time/Part-Time Employees)</th>
<th>Delta Dental Preventive (Available to Full-Time/Part-Time Employees)</th>
<th>Delta Dental Preventive (Only Available to Part-Time Employees)</th>
<th>Kaiser Network</th>
<th>Willamette Dental Group Office Visit copay $10 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible...</td>
<td>None</td>
<td>None</td>
<td>$0</td>
<td>$0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Annual maximum (max) coverage</td>
<td>$1,750</td>
<td>$1,750</td>
<td>$1,750</td>
<td>$1,750</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Diagnostic &amp; preventive services</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
<td>$0 Not subject to or counted toward Annual Maximum</td>
</tr>
<tr>
<td>Basic and maintenance services</td>
<td>$5 copay + 20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Crowns</td>
<td>$5 copay + 20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Implants</td>
<td>$5 copay + 20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Dentures</td>
<td>$5 copay + 20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>$5 copay + 20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

* Members can utilize any licensed providers on the Premier plans and receive in-network benefit level. However, the out-of-network providers may balance bill above the maximum plan allowance.

** Preventive services will not accrue toward the plan maximum.

† The $1500 annual max. coverage is separate from the $1,750 Annual (max) coverage.

** This information gives a high-level summary only. See plan documents for details.

### Vision Services Plan (VSP) Basic Plan

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well vision exam</td>
<td>Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Each calendar year</td>
</tr>
<tr>
<td>Prescription glasses</td>
<td>Included in prescription glasses</td>
<td>$25</td>
<td>Each calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>* $150 allowance for a wide selection of frames * $170 allowance for featured frame brands * 20% savings on the amount over your allowance</td>
<td>Included in prescription glasses</td>
<td>Each calendar year</td>
</tr>
<tr>
<td>Lenses</td>
<td>* Single vision, standard lenses * Standard progressive lenses * Polycarbonate lenses for dependent children</td>
<td>Included in prescription glasses</td>
<td>Each calendar year</td>
</tr>
<tr>
<td>Lens Enhancements</td>
<td>* Standard progressive lenses * Custom progressive lenses * Custom progressive lenses * Average savings on other lens enhancements</td>
<td>Included in prescription glasses</td>
<td>Each calendar year</td>
</tr>
<tr>
<td>Contacts (instead of glasses)</td>
<td>* $200 allowance for contacts and lenses</td>
<td>Included in prescription glasses</td>
<td>Each calendar year</td>
</tr>
</tbody>
</table>

** Please note, Kaiser Permanente Vision Benefits are included in the Medical coverage and can be found on the Medical Summary Comparison.
### Medical Plans Footnotes

1. To receive in-network benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or their medical home’s network. Additional copays, services, and/or deductibles may apply to out-of-pocket max. Not applied to out-of-pocket max.

2. These plans use a standard definition of Emergency Room (ER) admitted directly to the hospital for inpatient treatment.

3. These plans make copayments for non-emergency care, provided that a member pays the applicable in-network copay and/or deductible. Patients must be transported to the hospital for non-emergency care.

4. These plans offer copayments for non-emergency care, not subject to the applicable in-network copay.

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10. These plans offer copayments for non-emergency care, not subject to the applicable in-network copay.

11. The prescription drug out-of-pocket max. is $100 per person and, with a family maximum of $1000. It accrues separately from the medical deductible.

12. These plans cover the cost of routine preventive care.

13. Additional copays and/or deductibles may apply to out-of-pocket max. Not applied to out-of-pocket max.

14. These plans cover the cost of routine preventive care.

15. These plans offer copayments for non-emergency care, not subject to the applicable in-network copay.

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