MADDOCK & ASSOCIATES

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Employee Benefits Packet
For

Enclosed is an outline of the employee benefit program brought to you by db General Contractors and Maddock & Associates. The purpose of this packet is to give you a brief overview of the plans and assist you with enrollment. Maddock & Associates is your insurance advocate. Please call us at 800-875-4490 with your questions or benefits issues. We are here to help you! Your plan provides

- Medical & Prescription Drugs
- Dental
- Life & AD&D

1407 Willow Road E.
Fife, Washington 98424
(253) 854-0199

Creative Solutions • Continuous Service
www.medicalbenefits.com

Toll Free: (800) 875-4490
Fax: (253) 896-9411
ins@maddockinsurance.com

DB GENERAL CONTRACTORS EMPLOYEE BENEFITS ENROLLMENT

Your employer is pleased to offer you group medical, dental, and life insurance coverage. The purpose of this packet is to outline the plans, to advise you of the costs and to assist you with the enrollment. The required forms are attached. Below is a brief description of your plans. For full benefits and limitations please refer to the attached summaries. You will also to have 24-hour access to detailed plan summaries, provider directories, and important forms at the Maddock & Associates website, www.yourmedicalbenefits.com. YourMedicalBenefits LOGIN is **dbgc** and your PASSWORD is **dbgc123.**

ENROLLMENT FORMS

Anyone not enrolling at this time will NOT be eligible to enroll until December 1, 2012 unless they meet certain specific requirements, such as involuntary loss of other coverage through a spouse's employer, and apply immediately upon losing such coverage.

- **AWB Enrollment Form** (Medical & Life)
- **TPSC Enrollment Form** (Dental)

2012/2013 BENEFIT SUMMARY

MEDICAL INSURANCE: Premera Blue Cross through the Association of Washington Business. This plan provides the best benefits when you use Preferred Providers. There is a $2,000 annual deductible (maximum $6,000 per family). The deductible is waived for doctor office visits, lab and x-ray and prescription drugs. Office visits are covered at 100% after a $30 co-pay. For other services, the plan pays 80% after the deductible for services provided by Preferred physicians and Preferred hospitals. Non preferred, providers are covered at 50% after a $4,000 deductible. Preferred providers can be found in the provider directory section at www.yourmedicalbenefits.com, or at www.premera.com.

HEALTH REIMBURSEMENT ACCOUNT - HRA: db General Contractors will reimburse the deductible from $500 to $2,000 at 80% (3 times family). The maximum reimbursement is $1,200 for a single employee, $2,400 for employees with one dependent and $3,600 for employees with two or more dependents. A claim form with instructions is attached.

PRESCRIPTION DRUGS: Prescription Drugs are covered at a $15 co-pay for Generic drugs, $30 for Preferred Brand drugs and $50 for Non Preferred Brand drugs. The Premera drug formulary can be found at www.yourmedicalbenefits.com, or www. Premera.com.

LIFE INSURANCE: Lifewise Assurance. Each employee enrolled in the medical plan will also receive $15,000 of group life and accidental death & dismemberment insurance. This policy pays $30,000 if death results from an accident.

DENTAL INSURANCE: Washington Dental Premier Plan. This plan covers preventive care at 100%, restorative at 80% and major at 50%. There is a calendar year deductible of $50 per person which is waived for preventive benefits. The annual maximum is $1,500 per year. You may use the dentist of your choice, however, your out-of-pocket costs will almost always be lower if you use a participating dentist. A plan summary is attached. Preferred dentists can be found in the provider directory at www.deltadentalwa.com.

SECTION 125 PLAN: Section 125 of the Internal Revenue Code allows employer to set up a plan that allows you to pay for you and your dependents portion of medical and dental premiums on a tax-free basis. The premium amount is deducted from the payroll before taxes are figured…so you use your money tax-free. A brief summary of how this works is attached. Participation is voluntary. All employees will be automatically enrolled in the Section 125 plan.
If you do not wish to have your dependent premiums taken on a pre-tax basis, you must notify your plan administrator within 30 days of the date you are eligible.

ELIGIBILITY: All employees working a minimum of 20 hours per week are eligible for coverage effective the first of the month following 90 days of employment.

COSTS: db General Contractors will pay 75% of the employee's medical and dental premium. If you wish to add dependents please see Ann for the cots. *(The Child(ren) rates include all unmarried dependent children to age 26.*

FOR FURTHER INFORMATION feel free to contact any of the following:

Ann D'Unger…….(253) 736-2980
DB General Contractors Employee Benefit Website…….www.yourmedicalbenefits.com
Maddock & Associates…….(800) 875-4490
Premera Blue Cross Claims ……(800)-722-5561
Premera Website……www.premera.com
Delta Dental Claims…….(800) 367-4104
Delta Dental Website…….www.deltadentalwa.com

The above summary is an overview only and is not a guarantee of benefits. For complete description of benefits and limitations see your benefit book.

Premera BC: AWB Plan D 2000 $2,000 Deductible Grandfathered/Non-Grandfathered

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

Coverage Period: For plans renewing on or after 12/1/2012

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

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.awbhealthchoice.com or by calling 1-800-722-1471.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$2,000** individual /**$6,000** family Out-of-network **$4,000** individual/**$12,000** family Doesn't apply to in-network preventive care and pharmacy.	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. In-network: **$6,000** individual/**$18,000** family Out-of-network: None	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?	Premium, balance-billed charges, copays, pharmacy, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.premera.com or call 1-800-722-1471.	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?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-722-1471 or TDD/TTY 1-800-842-5357 or visit us at www.awbhealthchoice.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-722-1471 or TDD/TTY 1-800-842-5357 to request a copy.

- **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 $300. 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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay	50% coinsurance	none
	Specialist visit	$30 copay	50% coinsurance	none
	Other practitioner office visit	$30 copay	50% coinsurance	Spinal manipulations limited to 12 visits PCY, acupuncture limited to 12 visits PCY
	Preventive care/screening/ immunization	No charge	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.premera.com.	Generic drugs	$15 copay	$15 copay and 40% coinsurance	none
	Preferred brand drugs	$30 copay	$30 copay and 40% coinsurance	none
	Non-preferred brand drugs	$50 copay	$50 copay and 40% coinsurance	none
	Specialty drugs	$15 copay $30 copay $50 copay	$15 copay and 40% coinsurance $30 copay and 40% coinsurance $50 copay and 40% coinsurance	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay and 20% coinsurance	$100 copay and 20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$30 copay	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	——————none——————
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits PCY
	Rehabilitation services	$30 copay (outpatient) 20% coinsurance (inpatient)	50% coinsurance	Limited to 45 outpatient visits PCY, limited to 30 inpatient days PCY
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days PCY
	Durable medical equipment	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
	Hospice service	20% coinsurance	50% coinsurance	Limited to 10 inpatient days, 240 respite hours - 6 month overall benefit limit
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	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)
- Dental care (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- 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 (or other spinal manipulations)
- Non-emergency care when traveling outside the U.S.

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 1-800-722-1471. 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: Premera Blue Cross Customer Service at 1-800-722-1471, or you can contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol/gov/ebsa/healthreform. In addition, you can contact the Washington Consumer Assistance Program at 1-800-562-6900.

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 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:** $4,220
- **Patient pays:** $3,320

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	$2,000
Copays	$20
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$3,320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,020
- **Patient pays** $2,380

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	$1,400
Copays	$900
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,380**

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.

HealthChoice
Association of Washington Business

Vision Service Plan
Benefits Summary
Exam Plus Plan

Benefits	Services from a VSP Doctor	Services from an Out-of-Network Provider
Exam	Covered in full after $10 copayment Once every 12 months	Up to $42 Once every 12 months
Discount Benefits	**Services from a VSP Doctor**	**Services from an Out-of-Network Provider**
Prescription Glasses • Complete Pairs of	20 percent discount	Not Applicable
• Contact Lens Evaluation & Fitting	15 percent discount off professional fees (evaluation & fitting)	Not Applicable

The primary purpose of this VSP vision care plan is to provide professional eye exams and material discounts to help pay the cost of materials. When obtaining services from a VSP doctor, the exam is covered in full, less any applicable copayment. Members receive a 20 percent discount off the VSP doctor's usual and customary fees for complete pairs of prescription glasses. The discount includes lenses and lens characteristics chosen for cosmetic reasons. A 15 percent discount applies to the doctor's professional services for all types of prescription contact lenses. This discount applies to professional services only, materials are provided at usual and customary fees.

Obtaining services from a VSP doctor: When you want to obtain vision care services, call a VSP doctor to make an appointment. *For details on how you locate a VSP doctor, contact your benefits representative, call VSP at 800-877-7195 to request a VSP doctor list or go to vsp.com.* **Make sure you identify yourself as a VSP member and be prepared to provide the covered member's social security number.** The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you. VSP will pay the doctor directly for covered services and materials.

Obtaining services from an out-of-network provider: Services obtained from an out-of-network provider will be reimbursed up to amount on the above schedule less any copayment. For out-of-network reimbursement, pay the entire bill when you receive services, then send your itemized receipts and full patient and member information to VSP. Claims must be submitted to VSP within six months from your date of service. Please keep a copy of the information for your records and send the originals to the following address: Vision Service Plan, Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

ADDITIONAL BENEFITS: Laser Vision Correction: VSP's Laser VisionCare™ program is also available to those covered under this VSP WellVision® Plan. It is designed to provide members with a discount off laser surgery when obtained through VSP contracted doctors, surgeons, and laser centers. Call your VSP doctor to check if he or she is participating in the program. Doctors can also be located on VSP's Web site at vsp.com or by calling 888-354-4434.

When an exam is received from a VSP doctor, the patient will have no out-of-pocket expense other than the copayment.

THIS IS ONLY A SUMMARY
FOR FURTHER INFORMATION, SEE YOUR EMPLOYER'S BENEFIT REPRESENTATIVE
VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195
Visit our Web site at vsp.com

24-Hour NurseLine

Because your healthcare needs don't have a schedule, we offer peace of mind to members with round-the-clock access to the Premera Blue Cross Blue Shield of Alaska 24-Hour NurseLine

The 24-Hour NurseLine is fast, free, confidential and available any time, any day.

Helpful information

Nurses will listen to your concerns, answer your questions and offer advice about many health-related topics.

Their healthcare advice can help you to understand and better manage your condition, as well as provide peace of mind about what to expect or do about your health condition.

Helping you know where and when to seek care

Nurses are trained to ask the right questions, listen to your concerns, and help you determine where and when to seek treatment for an injury or illness. The nurse provides healthcare advice based on your symptoms and other relevant health conditions or history.

FREE and CONFIDENTIAL

All calls to the 24-Hour NurseLine are free, confidential and available 24 hours a day, 7 days a week. Call 800-841-8343.

24-Hour NurseLine

Speak with a registered nurse about your non emergency healthcare concerns

800-841-8343

In case of an emergency, CALL 911

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

The 24-Hour NurseLine is NOT a substitute for regular, scheduled care from your physician or healthcare provider.

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We know the territory.

012788 (09-2010)

Life and AD&D Benefit Summary

LIFEWISE ASSURANCE COMPANY
Life | Disability | Stop Loss

This summary of benefits explains the key features of the Group Life and AD&D benefits. The contract between LifeWise Assurance Company and the Association of Washington Business, and the benefit booklet set out the actual terms, conditions and exclusions of coverage. This summary of benefits is not a contract.

Benefit Amount	**$15,000**	**$30,000**	**$50,000**
Eligible Employees	Minimum 2 employees	Minimum 3 employees	Minimum 3 employees
Evidence of Insurability	No	Required if less than 10 eligible employees	Required if less than 10 eligible employees
Benefit Reduction	The Life and AD&D benefits reduce to 65% at age 65, reduce to 50% at age 70 reduce to 30% at age 75, further reduce to 20% at age 80 and terminate at retirement.		
Life Provisions			
Conversion	If all or part of the life insurance ends, the insured may convert the life insurance to an individual life policy without evidence of insurability. The maximum amount that can be converted is the amount the insured is eligible for at the time the coverage ends. The insured may convert a lower amount of life insurance. In order to convert to an individual policy, the insured must submit a written application and pay the first month's premium within 31 days after the group life insurance ends.		
Waiver of Premium	If the employee becomes disabled, we will waive the life insurance premium on the basic life insurance. If the employee has dependent life insurance, the premiums for the dependent will be waived as well. The employee must become disabled prior to his or her 60th birthday while insured under the life insurance policy and must remain continuously disabled for six months. The employee must submit a waiver of premium application and be approved for this waiver to apply. Disability waiver of premium for the life insurance will end when the employee is no longer disabled, when the employee fails to provide proof of disability or when the employee attains age 65.		
Accelerated Benefit	An accelerated benefit is an advance payment before death of a part of the life insurance benefit. If the employee qualifies for an accelerated benefit, up to 75% of the basic life benefit in force is payable. If an accelerated benefit is paid, the life insurance benefit otherwise payable to the named beneficiary will be reduced by the sum of the accelerate benefit. The premiums for the full amount of the benefit in force before the payment of the accelerated benefit must be paid until the employee ceases active work. At that time, the premiums will be waived.		
Dependent Life Benefit (Optional at the employer level)			
	$2,500 for spouse; $2,500 for children birth to 25 years.		

Life and AD&D Benefit Summary

AD&D Benefit	
The amount of the AD&D benefit payable is determined by the severity of the loss. If the employee is injured or dies as the result of an accident, the AD&D benefit payable will equal the amount of the employee's basic life insurance based on the following schedule:	
Loss	**Percent of AD&D benefit**
Life	100%
Quadriplegia	100%
Speech and hearing	100%
Both hands, both feet, sight of both eyes or any combination thereof	100%
One hand, one foot, or sight of one eye	50%
Hemiplegia	50%
Paraplegia	50%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Loss of more than one of the above in any one accident	100%

AD&D Provisions	
Seat Belt	If the employee was wearing the seat belt and dies in an automobile accident while riding or driving in a private passenger automobile, we will pay a benefit in addition to the AD&D benefit. The additional benefit will be 10,000.
Exclusions	The AD&D benefits will not be paid for losses that result from: • disease or bodily or mental infirmity, or medical treatment of such condition; • ptomaine or bacterial infection except for infections occurring through an accidental cut or would • participation in a riot; • suicide, or its attempt, while sane or insane, • intentionally self inflicted injuries; • war or any act of war that is declared or undeclared; or • attempt or commission of an assault or felony under state law

Life and AD&D Benefit Summary

Life and AD&D Definitions	
Accident	A sudden and unforeseen event, definite as to time and place.
Active Work or Actively At Work	The performance of the regular duties of an employee's work for the policyholder on a full-time basis. Such work must be performed: 1. at the employee's usual place of employment or as required by the policyholder; and 2. for not less than the minimum number of hours specified in the Schedule. An employee will be deemed to be actively working on a full-time basis on: 1. regularly paid vacation; and 2. regular non-work days on which the employee is not disabled, if the employee was at active work on a full-time basis on the last preceding regular work day.
Beneficiary	The person or entity to whom benefits for loss of life are payable.
Disabled or Disability	Refers to any disability which results from a sickness or injury that completely prevents the employee from engaging in any occupation for wage or profit for which the employee is or becomes reasonably qualified due to education, training, or experience.
Injury	Bodily injury which is caused by an accident and which results directly from the accident and independently of all other causes.
Loss	With regards to the AD&D Insurance means: • To the hand or foot", the actual severance of a hand or foot at or above the wrist or ankle joint. Loss does not mean the loss of function of a hand or foot due to injury. Severance" means the complete amputation of a hand or foot at or above the wrist or ankle joint. • To the thumb and index finger, the actual severance of the thumb below the thumb joint and below the second joint of the index finger. Loss does not mean the loss of function of the thumb and index finger due to injury. • Loss of an eye means the total and irrecoverable loss of sight. • Loss of speech means total and irrecoverable loss of audible communication. • Loss of hearing means permanent total deafness in both ears such that it cannot be correct to any functional degree by any aid or device. • Quadriplegia means complete and irreversible loss of the use (paralysis) of both upper and both lower limbs • Paraplegia means complete and irreversible loss of the use (paralysis) of both lower limbs • Hemiplegia means complete and irreversible loss of the use (paralysis) of the upper and lower limbs on one side of the body.

Chamber Benefit Services Fund
2012 CBSF WDS PPO Plan D

DELTA DENTAL
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

BENEFITS	Plan PPO (D) 2+ Employees	
	PPO	**Premier**
Annual Deductible		
Individual	**$50**	
Family	**$150**	
Annual Maximum (per calendar year)	**$1,500**	
CLASS I (Deductible Waived)		
Preventive & Diagnostic Exams Prophys Floride X-rays Sealants	**100%**	**80%**
CLASS II		
Restorative Restorations Endodontics Periodontics Oral Surgery	**80%**	**70%**
CLASS III		
Major Crowns Dentures Partials Bridges	**50%**	**40%**
Waiting Period	**NONE**	

	Plan #

ACCESSING CARE

How to use your Delta Dental PPO plan

The dental plan offered to your group is Delta Dental PPO, a preferred provider plan. You can choose any dentist — in or out of the PPO network — at the time of treatment. However, if you select a dentist who is part of the Delta Dental PPO network, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower.

Washington Dental Service will handle all customer service and claims processing for your plan. Tell your dentist you are covered by Washington Dental Service and give him or her your member identification number, the plan name and plan number.

Delta Dental PPO dentists

Delta Dental PPO dentists complete claim forms and submit them directly to Washington Dental Service. PPO dentists receive payment based on their pre-approved, discounted PPO fees and they cannot charge you more than these fees. You are responsible only for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums.

Delta Dental Premier® dentists — (non-PPO)

Delta Dental Premier dentists are members of our traditional fee-for-service plan, but they are not part of the PPO network; therefore, your out-of-pocket costs may be higher. Delta Dental Premier dentists will still submit claims for you and receive payment directly from Washington Dental Service. Their payment will be based upon their pre-approved fees with Washington Dental Service. They also cannot charge you more than these fees. You are responsible only for your stated deductibles, coinsurance and/or amounts in excess of the program maximums.

Finding a dentist

You can find a participating dentist in your area by visiting the Washington Dental Service Web site at **DeltaDentalWA.com.** Click on the *Patients* tab and then on the *Find A Dentist* tab to begin your search. **Be sure to select the appropriate plan — Delta Dental PPO or Delta Dental Premier — and follow the prompts.**

Nonparticipating dentists

You are not limited to visiting a Washington Dental Service dentist. If you choose a nonparticipating dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service. Claim payments will be based on actual charges or Washington Dental Service's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for any balance remaining. Please be aware that Washington Dental Service has no control over nonparticipating dentists' charges or billing procedures.

NOTE: For information on out-of-state dentists, please refer to your benefits booklet.

Predetermination (estimate) of benefits

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a "predetermination of benefits." This will allow you to know in advance what procedures are covered, the amount Washington Dental Service will pay and your financial responsibility. A predetermination of benefits is not a guarantee of payment.

SECTION 125 PREMIUM PLAN

Here's how it works:

This employee enrolled his eligible dependents on the medical plan ($195.00 per month for his spouse and $135.00 for the children). As you can see, he avoided paying taxes on the premiums he paid…and his spendable income increased.

ANNUAL SALARY: $30,000 MARITAL STATUS: Married

	Before Section 125 Plan	**After** Section 125 Plan
Annual Salary	$30,000.00	$30,000.00
Salary Reductions		
Health Insurance Premiums	0.00	$3,960.00
Taxable Income	$30,000.00	$26,040.00
Payroll Taxes		
7.65% FICA (fixed)	2,295.00	1,992.06
15% Federal Tax (variable)**	4,500.00	3,906.00
Total Taxes	6,795.00	5,898.06
After-Tax Pay	23,205.00	20,141.94
After-Tax Expenses		
Health Insurance Premiums	3,960.00	0.00
Actual Spendable Income	$19,245.00	$20,141.94

Annual Increase in Take-Home Pay: $896.94

** Federal Income Tax savings will vary based on your income and personal tax situation. In most cases, individual income taxes are higher than 15% and savings are more.

Participation in the Section 125 Premium Only Plan is optional. Since it decreases the amount of Social Security taxes you pay, those nearing retirement may wish to evaluate the impact of their participation with a representative of the Social Security Administration.

Premiums for dependents covered on your medical plan who are not IRS dependents (i.e. domestic partners or children over age 19 who are not living with you) cannot be included in a Section 125 Premium Only Plan. Please advise your HR department if you have this situation.

DB GENERAL CONTRACTORS EMPLOYEE BENEFITS BENEFITS, COMPLIANCE & NOTIFICATION SHEET

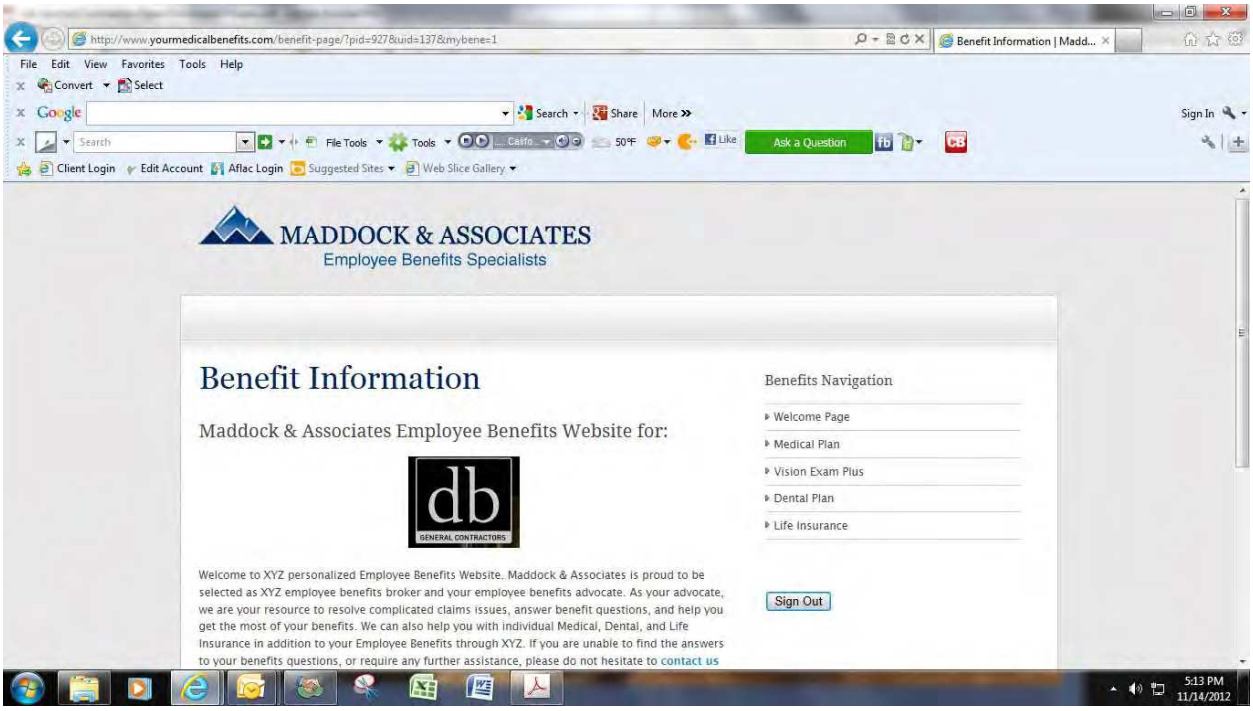
Below is a list of rights and notices that apply to you through the db General Contractors Employee Benefit plan. Please visit www.yourmedicalbenefits.com to download details about this important information. The log in and password are on the first page of this packet. Paper copies are available upon request from your HR department.

1. Erisa Summary Plan Description
2. Cobra Notice
3. Medicare Credible Coverage Notice
4. Section 125 Premium Reduction Plan Explanation of Benefits
5. HIPAA Special Enrollment Rights Notice
6. HIPAA Preexisting Condition Exclusion Notice
7. Uniform Services Employment and Reemployment Rights Act Notice
8. Women's Health and Cancer Rights Act Notice
9. Medicaid & Children's Health Insurance Notice (CHIP)

Your Employee Benefits Website

At Maddock & Associates we do everything possible to provide added value to all our clients. Our ability to offer our clients the best service possible has made us one of the top brokers in Washington State. Our latest value added service is on the Internet at **www.yourmedicalbenefits.com**. Each one of our clients receives a custom employee benefits website to keep their employees informed of their employee benefits.
Benefits of the website include:

- Employees have one place to find information about all their insurance plans, from any computer, 24 hours a day.
- Employees have instant access to on-line provider directories, employment change forms, and claim forms.
- Benefit administrators spend less time dealing with insurance issues.



www.yourmedicalbenefits.com
UserName = dbgc
PassWord = dbgc123

Employee Enrollment/Change Form

HealthChoice
Adding Value to Your Benefits

EMPLOYER NAME	EMPLOYER NUMBER

ENROLLMENT

Requested Effective Date: ___ / 01 / 201__

Employee Date of Hire: _____ / _____ / _____

Please check appropriate box:

- ☐ New employee
- ☐ New employee & dependent(s)
- ☐ New dependent(s) (Please specify qualifying event at right)
- ☐ **Entered Eligible Class Date** ____/___/_____

QUALIFYING EVENT FOR SPECIAL ENROLLMENT

Please check box below:

- ☐ Marriage/Domestic Partnership (Affidavit Required)
  Date of marriage/partnership _____/_____/_____
- ☐ Involuntary Loss of Coverage
- ☐ Adoption/Legal Guardian *(Legal documentation required)*
- ☐ Birth ☐ Divorce ☐ Death

CHANGE

Please check box below:

- ☐ Name Change ☐ Address Change
- ☐ Beneficiary Change
- ☐ Delete Employee(s) Effective date ____/___/_____
- ☐ COBRA / Continuation Coverage Start date ____ / 01 / 20_____

LINCOLN FINANCIAL GROUP VOLUNTARY BENEFITS

Voluntary Life			Short Term Disability Buy-up	Long Term Disability Buy-Up
Employee	Spouse	Dependent Child(ren)	☐ Yes ☐ No	☐ Yes ☐ No
☐ $25,000.00 ☐ $50,000.00 ☐ $75,000.00 ☐ $100,000.00	☐ $10,000.00 ☐ $20,000.00 ☐ $30,000.00 Spouse coverage must be 50% or less of the employee choice	☐ $10,000.00	$500 Weekly benefit, 3/6 pre-ex limitations on buy up amount only	Buy up benefit is limited to 60% of employee salary, up to $5000 Monthly benefit has a 3/12 pre-existing limitation on base and buy-up plans.
Rates & benefit reduce by age			Buy-up only available if your employer has purchased the base coverage	

For more details please refer to the benefit summaries. Please check with your producer or group adminstrator for your eligibility.

DENTAL PLAN SELECTION

If your Employer is enrolling 5 or more Employees and is choosing a Dental product you're responsible for selecting the carrier of your choice. If you have any questions your employer will gladly assist you during the enrollment process

- ☐ Premera DentalBlue
- ☐ Willamette Dental

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	Gender ☐ M ☐ F	Date of Birth / /

Mailing Address	Apt #	City, State, Zip

Social Security Number - -	Home Phone ( )	Work Phone ( )	Email

Are you covered by workers' compensation: ☐ Yes ☐ No ☐ Exempt | **Current Job Title**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership (Affidavit or State Registration Required)

Prior Coverage ☐ YES ☐ NO | Insurance Carrier: | Start date of prior coverage : _____/_____/_____ End date of prior coverage: _____/_____/_____

DEPENDENT INFORMATION (Please check the add or delete box for each enrollee)

Add ☐	Delete ☐	Relationship to employee	Last Name	First Name
			Social Security Number - -	Gender ☐ M ☐ F
			Date of Birth / /	
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /
			Prior coverage ended: / /	

Add ☐	Delete ☐	Relationship to employee	Last Name	First Name
			Social Security Number - -	Gender ☐ M ☐ F
			Date of Birth / /	
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /
			Prior coverage ended: / /	

Employee Enrollment/Change Form

HealthChoice
Adding Value to Your Benefits

EMPLOYER NAME	EMPLOYER NUMBER

DEPENDENT INFORMATION CONTINUED (Please check the add or delete box for each enrollee)

Add	Delete	Relationship to employee			
☐	☐		Last Name	First Name	
			Social Security Number - -	Gender ☐ M ☐ F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /

Add	Delete	Relationship to employee			
☐	☐		Last Name	First Name	
			Social Security Number - -	Gender ☐ M ☐ F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /

Add	Delete	Relationship to employee			
☐	☐		Last Name	First Name	
			Social Security Number - -	Gender ☐ M ☐ F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /

Add	Delete	Relationship to employee			
☐	☐		Last Name	First Name	
			Social Security Number - -	Gender ☐ M ☐ F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /

BENEFICIARY FOR EMPLOYEE'S LIFE INSURANCE BENEFIT

Beneficiary Name	**Beneficiary Address**	**Relationship to employee**

APPLICANT / HIPAA ACKNOWLEDGEMENT

I am an active full-time employee or owner regularly working at least 20 hours per week. All information given by me on this form is true and complete. My signature below attests that the prior coverage data provided above is complete and accurate to the best of my knowledge, and can be documented upon request with evidence of coverage from my, and my dependent's, prior plan(s). I authorize the Association of Washington Business to obtain information from third parties regarding any matters that may bear on this application.

I understand that AWB HealthChoice and the insurance carriers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out its routine business functions, which include, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting and conducting case management, care management and quality reviews. AWB HealthChoice and the insurance carriers may also disclose protected health information to state and federal agencies or other third parties as required or permitted by law.

FRAUD WARNING STATEMENT

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Any person who knowingly and with intent to defraud a health care service contractor or any other person files a request for benefit coverage or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which may result in the denial of health care coverage or insurance coverage.

This application must be signed *Please return this form to your employer*

Applicant Signature ______________________________ **Date** ____________________

Underwritten by:

Premera Blue Cross
7001 220th SW
Mountlake Terrace, WA 98043

Lincoln Financial Group
8801 Indian Hills Drive
Omaha, NE 68114

LifeWise Assurance Company
7007 - 220th SW
Mountlake Terrace, WA 98043

Premera DentalBlue
7001 220th SW
Mountlake Terrace, WA 98043

Vision Service Plan (VSP)
600 University St Ste 2004
Seattle, WA 98101

Willamette Dental of Washington, Inc.
181 S 333rd St Suite C-100
Federal Way, WA 98003

Administered By

TPSC TRUSTEED PLANS SERVICE CORPORATION

A PacificSource Company

P.O. Box 1894
Tacoma, WA 98401-1894
Phone: 800.426.9786
Fax: 253.564.5881

Member Application / Change Request Form for Group Coverage
Sponsored by the Chamber Benefit Services Fund

Dental offered and underwritten by the following carriers:	**Vision offered and underwritten by:**
DELTA DENTAL Washington Dental Service 9706 Fourth Avenue NE, Seattle, WA 98115-2157 Madison National Life Insurance Company Inc 1241 John Q Hammons Dr # 400, Madison, WI 53717-1929	Vision Service Plan 3333 Quality Drive, Rancho Cordova, CA 95670

EMPLOYER MUST COMPLETE THIS SECTION AND CHECK APPROPRIATE BOXES:

Dental Group #:	Vision Group #:	Add Employee Coverage	Change in Enrollment	
Group/Employer Name:		☐ New Group ☐ New Employee ☐ Open Enrollment ☐ Re-Employed ☐ Part Time-Full Time	☐ Name ☐ Address ☐ Dependent ☐ Death ☐ Marriage/Divorce	☐ Loss of Coverage ☐ Change in Coverage ☐ Adoption/Placement ☐ Open Enrollment: ☐ Transfer to COBRA
Employer Telephone #:	Department/Division:			
Original Hire Date:	Pt Time to Full Time Date:	Re-Hire Date: Hours Worked per Week:	**Intended Effective Date:**	
Employer Signature:		**Date Signed:**		

EMPLOYEE MUST COMPLETE THE FOLLOWING *(Even if coverage is being waived)*

Employee Last Name:	First Name:		M.I.	Suffix	Marital Status: ☐ Single ☐ Married	Date of Marriage:
Employee Address:	City:	State:	Zip:		Home Phone:	Work Phone:

If you are waiving coverage, please complete the name and address information directly above and check each box for the coverage being waived: ☐ ***Dental*** ☐ ***Vision*** *I have been offered benefits by my employer and I hereby decline enrollment in my employer's dental and/or vision plan.*
Reason for Waiving: _____

Subscriber: If you are a new applicant, please list all family members who are enrolling in any coverage offered by your employer. If this is a change to existing coverage, check the coverage that is being added or deleted ***for each dependent***, check the Add or Delete box, and then list the dependent's Name, social security #, sex, date of birth and relationship.

WDS DEN	MNL DEN	VSP VIS	ADD	DEL	Last Name First Name MI	Social Security #	Sex	Birth Date MM/DD/YY	Relationship
☐	☐	☐	☐	☐			☐ M ☐ F		**Self**
☐	☐	☐	☐	☐			☐ M ☐ F		☐ Spouse or State Reg. Dom. Partner
☐	☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other
☐	☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other
☐	☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other

I hereby grant permission to each carrier or service provider to release and receive any and all health records, as permitted by law, for purposes of treatment, payment and healthcare operations for anyone making application, enrolled hereunder, or added hereafter. This permission shall become effective immediately and shall remain in effect as long as necessary. I understand that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care.

I apply for enrollment with each carrier for myself and the listed dependents and certify that (a) to the best of my knowledge, we are eligible for the coverage requested; (b) I have reviewed the product information and understand the exclusions, limitations, and waiting periods stated therein; and (c) all information on this form is true, correct, and complete. The changes on this form supersede all previous forms I have submitted. ***I authorize my employer to deduct from my pay the amount, if any, to pay for the premiums for the coverage's I have elected.*** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

EMPLOYEE'S SIGNATURE _____ **DATE SIGNED** _____