MADDOCK & ASSOCIATES

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Employee Benefits Packet
For

Enclosed is an outline of the employee benefit program brought to you by Dorse & Company 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
- Vision
- Dental
- Life & AD&D
- Disability

Detailed benefit summaries and forms are available on-line at:

www.yourmedicalbenefits.com

Login: **dorse** Password: d**orse123**

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

Creative Solutions • Continuous Service
www.medicalbenefits.com

Toll Free: (800) 875-4490
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DORSE & COMPANY EMPLOYEE BENEFITS ENROLLMENT

Your employer is pleased to offer you group medical, dental, vision, life and disability 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 **dorse** and your PASSWORD is **dorse123**.

ENROLLMENT FORMS

Anyone not enrolling at this time will NOT be eligible to enroll until July 1, 2013 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. For dental, Anyone (employee or dependent) not enrolling at this time will be involuntary subject to late entrant penalties unless they meet certain specific requirements, such as loss of other coverage through a spouse's employer, and apply immediately upon losing such coverage.

- **WAHIT Enrollment Form** (Medical, Vision, Life)
- **Met Life Enrollment Form** (Dental)
- **Lincoln Financial Enrollment Form** (Disability)

2012/2013 BENEFIT SUMMARY

MEDICAL INSURANCE: Premera Blue Cross. Each employee will choose between two different medical insurance options: Secure $1,000 deductible and Secure $1,500 deductible. Plan summaries are attached. These plans provide the best coverage when you use a Preferred Provider. Blue Cross Preferred Providers can be found in the provider directory section of your website, www.yourmedicalbenefits.com, or at www.premera.com.

PREMERA BLUE CROSS SECURE $1,000: This plan has a $1.000 annual deductible (maximum $3.000 per family). The deductible is waived for doctor office visits and prescription drugs. There is a $35 office co-pay. For other services, the plan pays 80% after the deductible, for services provided by Preferred Physicians and Facilities. The in-network coinsurance maximum is $4,000/Year. Providers who are not in Premera's PPO Network are covered at 50% after a $2,000 deductible.

PREMERA BLUE CROSS SECURE $1,500: This plan has a $1.500 annual deductible (maximum $4.500 per family). The deductible is waived for doctor office visits and prescription drugs. There is a $35 office co-pay For other services, the plan pays 80% after the deductible, for services provided by Preferred Physicians and Facilities. The in-network coinsurance maximum is $5,000/Year. Providers who are not in Premera's PPO Network are covered at 50% after a $3,000 deductible.

PRESCRIPTION DRUGS (BOTH PLANS): Prescription Drugs are covered at a $10 co-pay for generic drugs, $40 for brand name drugs, $80 for non formulary drugs and 30% for specialty drugs. This plan has a mandatory generic provision which means that if there is a generic available and the member buys a brand drug, the member is responsible for the brand co-pay plus the difference in cost between the brand drug and the generic drug. Mail order drugs are covered for a 90 day supply at a copay of $25 generic, $100 brand and $200 non formulary. The Premera drug formulary can be found at www.yourmedicalbenefits.com, or at www.premera.com.

DENTAL INSURANCE: Met Life Dental Plan. This plan covers preventive care at 100%, basic 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. Met Life pays at the 90th percentile of usual and customary charges for all dentists, meaning 90% of Washington Dentists take the scheduled payment as payment in full. If you receive care from their Preferred list of dentists you will receive additional discounts. Preferred dentists can be found at www.yourmedicalbenefits.com or at www.metlife.com.

VISION: Vision Service Plan. VSP vision insurance covers an eye examination every year after a $10 co-payment and lenses and/or frames every 24 months for a $20 co-payment. In addition to the booklet, a list of VSP providers can be found at www.vsp.com. ***It is important to go to VSP providers, not Premera, to get the best vision coverage.*** All employees and dependents covered on the medical plan will be covered on the vision insurance. A plan summary is attached.

LIFE INSURANCE: Lifewise Assurance Company. Each employee enrolled in the medical plan will also receive $20,000 of group life and accidental death & dismemberment insurance. This policy pays $40,000 if death results from an accident.

LONG TERM DISABILITY INSURANCE: Lincoln Financial. 60% of income, up to a $10,000 benefit, is available after 90 days of continuous disability. Benefits are also available for partial disability. Please see the attached plan summary for details.

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. 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 40 hours per week are eligible for coverage effective the first of the month following their date of employment.

COSTS: Dorse & Company will pay for 100% of the costs for Secure $1,500 medical, vision, life and dental for employees. At your option and expense you may elect to enroll your eligible dependents on the medical and/or dental plan. Below are your costs. *(The Child(ren) rates include all unmarried dependent children to age 26).*

	MEDICAL/VISION Premera Secure $1,000	MEDICAL/VISION Premera Secure $1,500	DENTAL Met Life
	Semi-Monthly Deduction	Semi-Monthly Deduction	Semi-Monthly Deduction
Employee	**$22.31**	**Company Paid**	**Company Paid**
Emp+Spouse	**$344.11**	**$293.20**	**$23.22**
Emp+Sp+Child(ren)	**$510.87**	**$445.25**	**$46.70**
Emp+Child(ren)	**$188.22**	**$151.20**	**$19.82**

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

Lauren Leahy…….(206) 604-2780
Dorse Employee Benefit Website……www.yourmedicalbenefits.com
Maddock & Associates…….(253) 854-0199
Maddock & Associates Website…….www.medicalbenefits.com
Premera Blue Cross Claims ……..(800)-722-5561
Premera Website……ww.premera.com
Vision Service Plan……800) 877-7195
Vision Service Website…….www.vsp.com
Met Life Claims……(800) 275-4638
Met Life Website……..www.metlife.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.

MADDOCK & ASSOCIATES
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GROUP MEDICAL COMPARISON FOR
DORSE & COMPANY

CARRIER	WAHIT Premera Secure $1,000		WAHIT Premera Secure $1,500	
COST SHARES	In Network	Out of Network	In Network	Out of Network
Deductible (Calendar Year)	$1,000/Person $3,000/Family	$2,000/Person $6,000/Family	$1,500/Person $4,500/Family	$3,000/Person $9,000/Family
Coinsurance	80%	50%	80%	50%
Coinsurance Maximum (Excludes Deductible)	$4,000/Person $12,000/Family	$8,000/Person $24,000/Family	$5,000/Person $15,000/Family	$10,000/Person $30,000/Family
Office Visit Copays	$35 Copay	N/A	$35 Copay	N/A
Lifetime Limit	Unlimited		Unlimited	
PRESCRIPTIONS	**Premera In Network Services**		**Premera In Network Services**	
Generic	$10 Copay		$10 Copay	
Preferred Brand	$40 Copay		$40 Copay	
Non Preferred Brand	$80 Copay		$80 Copay	
Specialty	70%, to $6,000 out of pocket maximum		70%, to $6,000 out of pocket maximum	
Mail-Order (90 day supply)	2.5 times pharmacy cost		2.5 times pharmacy cost	
PROFESSIONAL CARE	**Premera In Network Services**		**Premera In Network Services**	
Preventive Office Visit	100%, Deductible Waived		100%, Deductible Waived	
Physician Office Visits	Copay, Deductible Waived		Copay, Deductible Waived	
Mental Health	Copay, Deductible Waived		Copay, Deductible Waived	
Chiropractic	Copay, Deductible Waived, 12 visits per year		Copay, Deductible Waived, 12 visits per year	
Acupuncutre	Copay, Deductible Waived, 12 visits per year		Copay, Deductible Waived, 12 visits per year	
Massage Therapy	Copay, DW, 30 vsts/yr (cmbnd rehabilitaion)		Copay, DW, 30 vsts/yr (cmbnd rehabilitaion)	
DIAGNOSTIC CARE	**Premera In Network Services**		**Premera In Network Services**	
Lab & Xray	80%		80%	
Preventive Mammography	100%, Deductible Waived		100%, Deductible Waived	
Preventive Screening	100%, Deductible Waived		100%, Deductible Waived	
FACILITY CARE	**Premera In Network Services**		**Premera In Network Services**	
Hospital	80%		80%	
Emergency Room Copay	$250 Copay		$250 Copay	
OTHER BENEFITS				
Life Insurance	$20,000			
Vision	Eye Exam per year & Hardware every 2 years			

The above is a summary description of benefits. For complete details and limitations, see company brochure.

Rates	*Semi-Monthly Deduction*	*Semi-Monthly Deduction*
Employee	$22.31	$0.00
Employee + Spouse	$344.11	$293.20
Emp,Spouse & Child(ren)	$510.87	$445.25
Employee + Child(ren)	$188.22	$151.20

Secure 1000 Medical Plan

Underwritten by Premera Blue Cross, an independent licensee of the Blue Cross Blue Shield Association

NETWORK Heritage	**COST SHARES REPRESENT WHAT YOU PAY**	
Individual Deductible Per Calendar Year Family 3x Individual	$1,000	$2,000
Coinsurance[1] (Member's percentage of costs, after deductible, based on allowable charges)	20%	50%
Individual/Family Coinsurance Maximum (Does not include deductible PCY)	$4,000 Individual / $12,000 Family	2 x the In-Network Coinsurance Maximum
Office Visit Copay	$35	Deductible then 50%
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE	Unlimited	Not Covered
Preventive Office Visit	Covered In Full	Not Covered
Immunizations	Covered In Full	
PROFESSIONAL CARE		
Professional Office Visit (Includes Urgent Care)	$35 copay[2]	Deductible then 50%
Other Outpatient Professional Services	Deductible then 20%	
Inpatient Professional Services		
ALTERNATIVE CARE		
Manipulations 12 visits PCY	$35 copay[2]	Deductible then 50%
Acupuncture 12 visits PCY		
Naturopathic Services		
DIAGNOSTIC SERVICES		
Mammography	Covered In Full	Deductible then 50%
Preventive Screening (includes Pap Smear and PSA Testing)		
Other Outpatient Diagnostic Imaging & Laboratory Services	Deductible then 20%	
EMERGENCY CARE		
Emergency Care (Copay waived if direct admit to inpatient facility)	$250 Copay, Deductible then 20%	
Ambulance Transportation (Air and ground)	Deductible then 20%	
FACILITY CARE		
Inpatient Care	Deductible then 20%	Deductible then 50%
Outpatient Facility Care		
Skilled Nursing Facility 90 days PCY		
MATERNITY CARE		
Maternity (Prenatal, delivery and postnatal care)	Deductible then 20%	Deductible then 50%
OTHER SERVICES		
Mental Health Care (Unlimited)	Outpatient: $35 copay[2] Inpatient: Deductible then 20%	Deductible then 50%
Chemical Dependency Treatment (Unlimited)		
Rehabilitation (Including Physical, Occupational, Speech and Massage Therapy; Cardiac-Pulmonary Rehab; and Chronic Pain) Outpatient: 30 visits PCY; Inpatient: 15 days PCY		
Medical Supplies, Equipment, Prosthetics and Orthotics (Unlimited)	Deductible then 20%	
Home Health Care 130 visits PCY		
Hospice Health Care Hospice unlimited within 6 month period PCY; Respite 240 hours PCY		
Transplants (Organ & Bone Marrow) (Unlimited) 6-month waiting period	Outpatient: $35 copay[2] Inpatient: Deductible then 20%	Not Covered
Temporomandibular Joint Disorders (TMJ)	Not Covered	
PRESCRIPTION Rx[3,4,5,6] Tier 1 / Tier 2 / Tier 3 / Tier 4		
Retail 30-day Supply	Tier 1/Tier 2/Tier 3: $10/$40/$80 Tier 4: Member pays 30% up to a $6,000 individual out-of-pocket max for specialty drugs[7]	Tier 1/Tier 2/Tier 3: $10/$40/$80 +50% Tier 4: Not Covered
Mail Order 90-day Supply	Tier 1/Tier 2/Tier 3: $25/$100/$200 Tier 4: Member pays 30% up to a $6,000 individual out-of-pocket max for specialty drugs[7]	Tier 1/Tier 2/Tier 3: $25/$100/$200 +50% Tier 4: Not Covered
LIFETIME BENEFIT MAXIMUM	Unlimited Lifetime Max	

Copays do not apply towards the deductible or coinsurance maximum. PCY = Per Calendar Year. [1]All coinsurance amounts are based on a percentage of allowable charges after the deductible is met. [2]Not subject to deductible or coinsurance. [3]Not subject to deductible. [4]WAHIT prescription coverage is considered "creditable coverage" under Medicare Part D. [5]4th tier is for specialty drug, Specialty Pharmacy is required. [6]Member pays brand name copay plus cost difference between generic and brand name drug when generic is available. [7]Tier 4 out-of-pocket max is separate from medical out-of-pocket max.

PREMERA BLUE CROSS

Secure 1500 Medical Plan

Underwritten by Premera Blue Cross, an independent licensee of the Blue Cross Blue Shield Association

NETWORK Heritage	**COST SHARES REPRESENT WHAT YOU PAY**	
Individual Deductible Per Calendar Year Family 3x Individual	$1,500	$3,000
Coinsurance[1] (Member's percentage of costs, after deductible, based on allowable charges)	20%	50%
Individual/Family Coinsurance Maximum (Does not include deductible PCY)	$5,000 Individual / $15,000 Family	2 x the In-Network Coinsurance Maximum
Office Visit Copay	$35	Deductible then 50%
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE	Unlimited	Not Covered
Preventive Office Visit	Covered In Full	Not Covered
Immunizations	Covered In Full	
PROFESSIONAL CARE		
Professional Office Visit (Includes Urgent Care)	$35 copay[2]	Deductible then 50%
Other Outpatient Professional Services	Deductible then 20%	
Inpatient Professional Services		
ALTERNATIVE CARE		
Manipulations 12 visits PCY	$35 copay[2]	Deductible then 50%
Acupuncture 12 visits PCY		
Naturopathic Services		
DIAGNOSTIC SERVICES		
Mammography	Covered In Full	Deductible then 50%
Preventive Screening (includes Pap Smear and PSA Testing)		
Other Outpatient Diagnostic Imaging & Laboratory Services	Deductible then 20%	
EMERGENCY CARE		
Emergency Care (Copay waived if direct admit to inpatient facility)	$250 Copay, Deductible then 20%	
Ambulance Transportation (Air and ground)	Deductible then 20%	
FACILITY CARE		
Inpatient Care	Deductible then 20%	Deductible then 50%
Outpatient Facility Care		
Skilled Nursing Facility 90 days PCY		
MATERNITY CARE		
Maternity (Prenatal, delivery and postnatal care)	Deductible then 20%	Deductible then 50%
OTHER SERVICES		
Mental Health Care (Unlimited)	Outpatient: $35 copay[2] Inpatient: Deductible then 20%	Deductible then 50%
Chemical Dependency Treatment (Unlimited)		
Rehabilitation (Including Physical, Occupational, Speech and Massage Therapy; Cardiac-Pulmonary Rehab; and Chronic Pain) Outpatient: 30 visits PCY; Inpatient: 15 days PCY		
Medical Supplies, Equipment, Prosthetics and Orthotics (Unlimited)	Deductible then 20%	
Home Health Care 130 visits PCY		
Hospice Health Care Hospice unlimited within 6 month period PCY; Respite 240 hours PCY		
Transplants (Organ & Bone Marrow) (Unlimited) 6-month waiting period	Outpatient: $35 copay[2] Inpatient: Deductible then 20%	Not Covered
Temporomandibular Joint Disorders (TMJ)	Not Covered	
PRESCRIPTION Rx[3,4,5,6] Tier 1 / Tier 2 / Tier 3 / Tier 4		
Retail 30-day Supply	Tier 1/Tier 2/Tier 3: $10/$40/$80 Tier 4: Member pays 30% up to a $6,000 individual out-of-pocket max for specialty drugs[7]	Tier 1/Tier 2/Tier 3: $10/$40/$80 +50% Tier 4: Not Covered
Mail Order 90-day Supply	Tier 1/Tier 2/Tier 3: $25/$100/$200 Tier 4: Member pays 30% up to a $6,000 individual out-of-pocket max for specialty drugs[7]	Tier 1/Tier 2/Tier 3: $25/$100/$200 +50% Tier 4: Not Covered
LIFETIME BENEFIT MAXIMUM	Unlimited Lifetime Max	

Copays do not apply towards the deductible or coinsurance maximum. PCY = Per Calendar Year. [1]All coinsurance amounts are based on a percentage of allowable charges after the deductible is met. [2]Not subject to deductible or coinsurance. [3]Not subject to deductible. [4]WAHIT prescription coverage is considered "creditable coverage" under Medicare Part D. [5]4th tier is for specialty drug, Specialty Pharmacy is required. [6]Member pays brand name copay plus cost difference between generic and brand name drug when generic is available. [7]Tier 4 out-of-pocket max is separate from medical out-of-pocket max.

Washington Alliance for Healthcare Insurance Trust (WAHIT©2012)
Revised February 2012; Effective July 1, 2012 through June 1, 2013

PREMERA BLUE CROSS

WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

BASE VISION BENEFIT

UNDERWRITTEN BY VSP®

An exam from a VSP network doctor is covered in full after a $10 copay. If lenses and/or frames are selected, there is a $20 copay.

BASIC COVERAGE	VSP NETWORK DOCTOR	OUT-OF-NETWORK PROVIDER
EXAM Once every 12 months *	Exam covered in full after $10 copay	Reimbursed up to $45 allowance after $10 copay
LENSES Lenses once every 24 months * Single vision Lined Bifocal Lined Trifocal ***FRAMES*** Frames once every 24 months *	Lenses and frame are covered in full after your $20 copay Covered in full [1] Covered in full [1] Covered in full [1] Frame of your choice covered up to $130 allowance. Plus 20% off the amount over your allowance [1] See ***Value Added Discounts & Savings*** below for discounts on the purchase of additional pairs of glasses.	Reimbursed up to the following, after $20 copay Reimbursed up to $45 allowance Reimbursed up to $65 allowance Reimbursed up to $85 allowance Reimbursed up to $47 allowance
CONTACTS Once every 24 months, in lieu of lenses and frames *	Covered up to $130 allowance [2] No copay applies	Reimbursed up to $105 allowance No copay applies

* Based on last date of service.

[1] When you visit a VSP Network Doctor, you will receive on average 35-40% savings on any non-covered cosmetic lens options such as scratch resistant, reflective coatings, progressive lenses, etc., plus 20% of the amount over your frame allowance..

[2] You will receive a 15% discount off of the cost of the contact lens exam (fitting and evaluation). When you choose contacts instead of glasses, your contact lens allowance applies to the cost of your contacts and the fitting and evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.

VALUE ADDED DISCOUNTS AND SAVINGS WHEN USING A VSP NETWORK DOCTOR:

Prescription Glasses:

- Polycarbonate lenses for dependent children covered in full.
- On average 35-40% savings on lens options such as scratch resistant and anti-reflective coatings and progressives.
- Additional Pairs of Prescription glasses, Prescription Sunglasses, and non-prescription sunglasses: If you choose contacts, but also wear prescription glasses or require a pair of non-prescription sunglasses, you'll benefit from valuable savings of 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off the cost of non-covered pairs of glasses (lenses and a frame) within 12 months from a VSP network doctor. The same applies if you obtain prescription glasses, but also wish to purchase an additional pair not covered by the plan, including prescription sunglasses.

Contacts:

- 15% off the costs of the contact lens exam (fitting and evaluation), available from any VSP doctor within 12 months of your last eye exam.
- Current soft contact lens wearers may also qualify for VSP's Contact Lens Care Program that includes a contact lens exam and initial lens supply. Learn more from your VSP network doctor or vsp.com.

Laser VisionCare Program:

- If you are considering laser vision correction, VSP can help you make an informed decision. VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering access to laser vision correction surgery for hundreds of dollars less than what you might pay privately. Discounts vary by location, but average 15% off of the laser center's usual and customary price. Additionally, if the laser center is offering a temporary price reduction, VSP members will receive 5% off of the advertised price.
- Visit www.vsp.com to learn more about this exciting program.

WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

BASE VISION BENEFIT

UNDERWRITTEN BY VSP®

Using Your VSP Benefit:

VSP delivers benefits to you without requiring you to complete a request card or benefit form. The VSP network doctor will contact VSP on your behalf to obtain authorization for services. Follow the convenient steps below, and you'll be on the way to quicker and easier vision care benefits!

1. Consult pages 1 and 2 of this form for a description of your vision plan coverage. If you do not already have a VSP network doctor, ask your benefits administrator for a list of doctors in your area. You may also call VSP at 800-877-7195 or check the Web site at www.vsp.com
2. The next step is to call a VSP network doctor for an appointment and identify yourself as a VSP member. When you call, the VSP network doctor will also ask for the last 4 digits of the covered member's identification number (usually Social Security number) and the organization that provides your benefits (i.e., Washington Alliance For Healthcare Insurance Trust).
3. After you've scheduled your appointment, the VSP network doctor will contact VSP to verify your eligibility and plan coverage. The doctor will also obtain authorization from VSP for services and eyewear.

If services are obtained from an Out-of-Network provider, follow the steps below:

1. Send a copy of the itemized bill(s) to VSP. The following information **must** also be included in your documentation:
    - Member's name, phone number and mailing address.
    - Last 4 digits of the Covered Member's Social Security number, and Date of Birth.
    - Member's employer or group name (Washington Alliance for Healthcare Insurance Trust)
    - Patient's name, relationship to member, address, phone number and date of birth.
2. You may submit the above information on an HCFA-1500/CMS-1500 form or any generic insurance claim form that may be available from your non VSP provider upon request.
3. Please mail the itemized bill(s) with the above information to the following address: VSP, Out of Network Claims, P.O. Box 997105, Sacramento, California, 95899-7105
4. If you have Internet access, you can also sign on to VSP's Web site at www.vsp.com using your member ID, select ***Out of Network Reimbursement*** under ***Benefit Resources*** and follow the instructions.

This summary of benefits explains the key features of your VSP Base Vision program. **This summary of benefits is not a contract**.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

UNDERWRITTEN BY LIFEWISE ASSURANCE COMPANY

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

EMPLOYEE LIFE INSURANCE

Summary of Benefits

The Employee Life Insurance plan provides a death benefit to your designated beneficiary in case of your death, regardless of the cause of death. The minimum amount of life insurance you may have is $20,000. Your employer may elect to provide a higher benefit. Please check with your employer to identify your benefit.

If you are age 65 or older, your life insurance benefits will be reduced according to the following schedule:

Your Age	Reduction Percentage
65 but less than 70	65%
70 but less than 75	50%
75 but less than 80	30%
80 or older	20%

Designating Your Beneficiary

In the case of your death, your life insurance benefits will be paid to your designated beneficiary. If no beneficiary is living or named, your life insurance benefits may be paid to your surviving family members in the following order: your spouse or domestic partner, your children, your parents, your brothers and sisters and your executors or administrator. You may change your designated beneficiary at any time by completing and signing a Beneficiary Change Form.

***Please note**:* If you are married and residing in a community property state, your spouse's written consent will be required to designate or change your beneficiary if the intended beneficiary is anyone other than your spouse. Even if you name someone other than your spouse as beneficiary, your spouse is entitled to 50% of your benefit. The term spouse also includes a domestic partner.

Disability Waiver of Premium

If you are Disabled, LifeWise Assurance Company will waive your life insurance premiums on the employer paid coverage if you become disabled prior to your 60th birthday while you are insured under the life insurance policy; and after you have been continuously disabled for six months. You must submit a waiver of premium application and be approved for this waiver.

Disability waiver of premium for your life insurance will end when you are no longer disabled, when you fail to give us proof you are disabled or when you attain Social Security Normal Retirement Age.

Accelerated Benefit

An accelerated benefit is an advance payment (before death) of a part of your employer-paid life insurance benefit up to $200,000.

If you qualify for an accelerated benefit, you will receive 75% of your life insurance amount in effect. If an accelerated benefit is paid, the life insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of the accelerated benefit.

The premiums for the full amount of your benefit in force before the payment of the accelerated benefit must be paid until you cease active work. At that time, your premiums will be waived under the Disability Waiver of Premium.

Repatriation Benefit

An additional benefit will be paid for the preparation and transportation of your body to a mortuary near your primary place of residence if you suffer a loss of life at least 100 miles away from your principal place of residence. The amount paid under this benefit will be the expenses to prepare and transport your remains to a mortuary near your primary place of residence, but not to exceed $5,000 or 10% of the Basic AD&D benefit, whichever is less.

When Coverage Ends

Your life insurance coverage ends on the earliest of the following:

- The date that your employer terminates coverage under the group policy
- The date the group policy terminates
- The date you cease to be an active employee
- The date you cease to be eligible for coverage with your employer

If you cease active work because of a temporary layoff or leave of absence, including a military leave of absence, you may continue your life and AD&D insurance by paying the required premium to your employer. You may continue your coverage for a maximum of three months.

If you cease active work because of a sickness or an injury, you may continue your life and AD&D insurance for a maximum of six months.

BASIC LIFE INSURANCE (CONTINUED)

Converting to Individual Coverage

If all or part of your life insurance ends for reasons other than termination of the policy, you may convert your insurance to an individual life policy without evidence of insurability. The maximum amount that you can convert is the amount you are insured for at the time your coverage ended. You may convert a lower amount of life insurance if you choose. In order to convert to an individual policy, you must send in a written application and pay the first premium within 31 days after your group life insurance ends.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Summary of Benefits

In addition of your life insurance, AD&D benefits provide financial protection for your beneficiaries by paying a benefit in the event of your death or for you in the event of any other covered loss. The AD&D benefit amount is equal to your Life Insurance benefit.

If You Are Age 65 or Older

If you are age 65 or older, your AD&D insurance benefit will be reduced according to the following schedule:

Your Age	Reduction Percentage
65 but less than 70	65%
70 but less than 75	50%
75 but less than 80	30%
80 or older	20%

What AD&D Insurance Pays for Your Losses

The amount of the benefit is determined by the severity of the loss. If you are injured or die as a result of an accident, the AD&D plan will pay benefits equal to the amount of your coverage according to the following schedule:

Loss of:	Benefit Amount
Life	Full amount
Two or more members	Full amount
One member	One half of the full amount

If you suffer more than one loss, the maximum benefit payable will not be more than 100% of the AD&D benefit.

Loss of Thumb & Index Finger of Same Hand

Loss of:	Benefit Amount
Thumb and index finger of same hand	25% of the full amount

Speech and/or Hearing Benefit

Loss of:	Benefit Amount
Speech and hearing	Full amount
Speech or hearing	50% of the full amount

Paralysis Benefit

Loss of:	Benefit Amount
Quadriplegia	Full Amount
Paraplegia	75% of full amount
Hemiplegia	50% of full amount

Note: Cerebrovascular accident (CVA), commonly called "stroke", is not an injury as defined in the policy.

Paralysis must be a direct result of an accidental bodily injury sustained while insured under the policy. Paralysis must occur within one year from the date of the accident causing the paralysis to receive benefits.

Day Care Benefit

If you die as a result of and within a year of a covered accident, the surviving parent will be reimbursed the lesser of 10% of your AD&D benefit or $10,000 a year for four years for actual expenses incurred for day care services. An eligible dependent must be between the ages of birth and five years at the date of the accident and may be enrolled up to one year after the date of the accident.

Coma Benefit

If as a result of a covered accident you are injured, the plan will pay an additional benefit if you become comatose within 31 days of the accident, and remain comatose beyond the waiting period. The waiting period is the 31-day period from the date you become comatose.

The plan will pay this benefit at the rate of 5% of your AD&D benefit per month from the end of the waiting period.

Payment will end on the earliest of:

- the end of the month in which you die;
- the end of the 11th month for which this benefit is payable;
- the end of the month in which you recover from the coma.

If you:

- die from any cause or as a result of the covered accident while this coma benefit is payable; or
- remain comatose after this coma benefit is payable for 11 straight months,

the plan will pay an amount equal to 100% of the AD&D death benefit, less any payments already made under the

- accidental dismemberment provision; or
- loss of sight, speech or hearing provision; or
- paralysis provision; or
- coma provision.

Total benefits paid under this provision will not exceed 100% of principal sum.

Seat Belt Benefit

If you were wearing your seat belt and you die in an automobile accident while driving or riding in a private passenger automobile, the plan will pay a benefit in addition to your AD&D benefit. The additional benefit payable is $10,000.

Airbag Benefit

This benefit will be payable if the seat belt benefit is payable and the airbag in your vehicle inflates on impact. The benefit payable is the greater of 10% of the AD&D benefit payable or $10,000.

ACCIDENTAL DEATH & DISMEMBERMENT (CONTINUED)

Spouse Retraining

If you die within one year of a covered accident and your spouse enrolls in any school for the purpose of retraining or refreshing skills needed for employment, the plan will reimburse the incurred expenses for two years after the first retraining course to a maximum of $5,000.

Education Benefit

If you die in a covered accident, this benefit will reimburse tuition expenses for child enrolling for higher education within one year after the date of your death. Benefit will not exceed $5,000 per year, or the cumulative total of $20,000 or 25% of the AD&D benefits, whichever is less.

Common Disaster Benefit

If you and your spouse suffer loss of life as the result of the same accident, your AD&D benefit will be increased to 200%. This benefit is payable to your dependents under the age of 25. If you do not have any eligible dependents, this benefit will not be paid.

Survivor Benefit

If you die as a result of a covered accident, your eligible dependents will receive an additional benefit. The additional lump sum benefit is equal to 30% of your AD&D benefit. If you do not have any eligible dependents, this benefit will not be paid.

Occupational Assault Benefit

If, while you are performing the customary duties of your occupation at your employer's place of business, you suffer a covered loss due to an assault, an additional AD&D benefit is payable. The benefit amount is 25% of the AD&D benefit to a maximum of $5,000.

Disappearance Benefit

If you disappear as a result of a covered accident which could have caused loss of life and you are not found within one year from the date of the accident, we will presume that you died. The benefit is equal to the AD&D benefit and will replace any other AD&D benefit payable for the same accident.

Exposure Benefit

If you suffer a loss as a result of exposure to natural elements as the result of a covered accident, we will pay the applicable for the loss. The benefit is equal to AD&D benefit and will replace any other AD&D benefit payable for the same accident.

AD&D Exclusions

AD&D benefits will not be paid for the following losses:

- disease or bodily or mental infirmity, or medical or surgical treatment of such condition;
- ptomaine or bacterial infection except for infections occurring through an accidental cut or wound;
- participation in a riot;
- suicide, or its attempt, while sane or insane, or intentionally self-inflicted injury;
- war or any act of war that is declared or undeclared; or
- attempt or commission of an assault or felony under state law.

Beneficiary

You will receive the Dismemberment benefits, if living. Otherwise, the same individual(s) named as beneficiary for your life insurance will receive the benefits for your AD&D benefits.

When Coverage Ends

Your AD&D insurance ends on the earliest of the following:

- The date the your employer terminates coverage under the group policy
- The date the group policy terminates
- The date you cease to be an active employee
- The date you cease to be eligible for coverage with your employer

Your AD&D coverage is not convertible.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Definitions for Life and AD&D Insurance

Accident means a sudden and unforeseen event, definite as to time and place.

Active work and **actively at work** mean you are performing your regular work duties for your employer on a full-time basis. You must be performing this work:

- at your usual place of employment or as required by your employer; and
- for not less than the minimum number of hours specified by your employer.

You will be considered to be actively working on a full-time basis on a regularly paid vacation and on any regular non-work days which you are not disabled if you were at active work on a full time basis on the last preceding regular work day.

Beneficiary means the person(s) whom you designate to receive your insurance benefits in case of your death.

With regards to AD&D Insurance, **Comatose** or **in a coma** means you are in a profound stupor or state of complete and total unconsciousness, as the result of an accident.

Disability or Disabled means any disability that results from a Sickness or Injury that completely prevents you from engaging in any occupation for wage or profit for which you are or become reasonably qualified due to education, training or experience.

Injury means a bodily injury that occurs while you are insured under the group policy, and is the direct result of an accident and not related to any other cause.

Loss, with regards to AD&D Insurance, means,

- to the hand or foot, complete severance through or above the wrist or ankle joint;
- to the thumb and index finger, actual severance of the thumb below the thumb joint and below the second joint of the index finger.
- Loss of an eye means 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.

Member, with regard to AD&D Insurance, means hand, foot or eye.

Claim Forms

You may obtain claim forms on the WAHIT website or by contacting your employer.

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.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

We know the territory.

012788 (09-2010)

Dental Benefits from MetLife

Dental coverage designed for the real world.

MetLife®

Network Comprehensive Dental Plan Design for: **Dorse & Company** Effective Date: July 1, 2011

Choice, Service, Savings.

To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Coverage Type:	**In-Network**[1]	**Out-of-Network**[1]
Type A – Preventive	100% of PDP Fee[2]	100% of R&C Fee[4]
Type B - Basic Restorative	80% of PDP Fee[2]	80% of R&C Fee[4]
Type C - Major Restorative	50% of PDP Fee[2]	50% of R&C Fee[4]
Deductible[3]		
Individual	**$50**	**$50**
Family	**$150**	**$150**
Annual Maximum Benefit:		
Per Person	**$1,500**	**$1,500**

[1] "In-Network Benefits" means benefits under this plan for covered dental services that are provided by a Participating PDP Provider. "Out-of-Network Benefits" means benefits under this plan for covered dental services that are not provided by a Participating PDP Provider.

[2] PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.

[3] Applies to Type B and C services only.

[4] Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

An Example of Savings When You Visit a Participating PDP Dentist

Save on out-of-pocket expenses when you receive services from one of more than 80,000 participating PDP dentists who generally agree to charge fees 10-35% lower than the average charges in your area.

Your Dentist says you need a Crown, a Type C Service
PDP Fee: $850.00 R&C Fee: $1100.00
Dentist's Usual Fee: $1100.00

* Please note: this example assumes that your annual deductible has been met.

(IN-NETWORK) When you receive care from a Participating PDP dentist...		**(OUT-OF-NETWORK)** When you receive care from a Non-Participating PDP dentist…	
The PDP Fee is:	$850.00	Dentist's Usual Fee is:	$1100
Your Plan Pays:		Your Plan Pays:	
(50% x $750 PDP Fee)	- $425.00	(50% x $930 R&C Fee)	- $550.00
Your Out-of-Pocket Cost:	$425.00	Your Out-of-Pocket Cost:	$550.00

Frequency & Allocations / Exclusions

Class Description: All Active Full Time Employees	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
Examinations	1 time in 6 months
Examinations – Problem Focused	Combined with Examinations Limit
Prophylaxis: Cleanings	1 time in 6 months
Sealants	1 per molar in lifetime for a child under age 14
Space Maintainers	No Limit for a child under age 14
Fluoride	1 time in 12 months for a child under age 14
Full Mouth X-Rays	Once in 60 months
Bitewing X-Rays	For a child under 19: 1 time in 12 months Adult: 1 time in 12 months
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
Amalgam Fillings	1 replacement per surface in 24 Months
Root Canal	1 in 24 months
Periodontal Maintenance	4 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 4)
Periodontal Surgery	1 per quadrant in any 36 month period
Scaling & Root Planing	1 per quadrant in any 24 month period
Labs & Other Tests	
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Rays	
General Anesthesia	
Resin Composite Fillings	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
Apexification & Recalcification	
Periodontal Surgery – Soft & Connective Tissue Grafts	
Periodontics – Non-Surgical	
Oral Surgery: Simple Extractions	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
Cone Beam Imaging	1 in 10 calendar years
Consultations	2 in 12 months
Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 10 calendar years
Crown Buildups / Post Core	1 per tooth in 10 calendar years
Repairs	1 in 24 months
Recementations	1 in 24 months
Dentures	1 in 10 calendar years
Immediate Temporary Dentures – Complete / Partial	1 replacement in 12 months
Dentures – Rebases / Relines	1 in 36 months
Denture Adjustments	No limit
Fixed Bridges	1 in 10 calendar years
Inlays / Onlays /Crowns	1 replacement per tooth in 10 calendar years
▪ Implant Services	▪ 1 per tooth position in 10 calendar years
▪ Implant Repairs	▪ 1 per tooth in 10 calendar years
▪ Implant Supported Prosthetic	▪ 1 per toothin 10 calendar years
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months
▪ General Services	

Exclusions
All Active Full Time Employees

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.

MetLife Preferred Dentist Program (PDP) Overview
Frequently Asked Questions

How does the MetLife PDP work?

With a dental benefit plan featuring the MetLife PDP, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower, out-of-pocket expenses. The MetLife PDP is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

What is a participating PDP dentist?

A general dentist or specialist who meets MetLife's strict credentialing standards and accepts negotiated fees as payment-in-full for services rendered. There are more than 76,000 participating PDP dentists nationwide, including over 15,000 specialists. So you should have no problem finding a participating PDP dentist near your home or workplace, while you're away on vacation, or while your covered dependents are away at college.

How do I find a Participating PDP dentist?

You can call the PDP automated Computer Voice Response line to obtain an up-to-date directory of participating dentists in your area. The system prompts you to enter your Social Security Number and a home or work ZIP code. A list of up to 205 participating dentists in the requested ZIP code is then mailed to your home the next business day. To receive your personalized directory, call 1-800-474-PDP1 (7371) Mon.-Fri. 6:00am to 11:00 pm ET or Saturday 7 am to 4:00 pm ET. You can also conduct online provider searches (with direction and mapping capabilities) via MetLife's Dental Internet site at www.metlife.com/dental**.**

Please Note: Be sure to verify provider participation when you make your appointment.

What is a negotiated fee?

A negotiated fee refers to the PDP fee schedule which participating dentists agree to accept as payment in full. The fee is typically 10% to 35% below average fees of dentists in your area. Your plan may reimburse you for all or part of the PDP fee. When you use a participating PDP dentist, you are responsible only for the difference between MetLife's benefit payment amount and the PDP fee.

Do I need an ID card?

No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system

Do my dependents have to visit the same dentist that I select?

No, you and your dependents each have the freedom to choose any dentist.

My dentist does not participate in the PDP. Is there anything I can do to encourage my dentist to participate?

The MetLife PDP Network is continually expanding, and new providers may be added if they meet MetLife's credentialing standards. You may ask your dentist to complete a MetLife PDP nomination card or visit the dentist directory online at www.metlife.com/dental**,** and MetLife will send him or her information on how to apply for participation. The timing depends on how quickly MetLife receives the necessary information. Please note that there may be instances where a dentist chooses not to participate and others where MetLife does not accept the application under their stringent credentialing requirements.

Can I find out how much services will cost and obtain an estimate of what will be covered prior to treatment?

Yes, MetLife recommends that you have your dentist submit a request for a pre-treatment estimate for services in excess of $300.00. This often applies to services such as: crowns, bridges, inlays, and periodontics. When your dentist suggests treatment, have him or her send an undated claim form, along with the proposed treatment plan, to MetLife. A pre-treatment estimate will be sent to you and the dentist detailing an estimate of what services your plan will cover and at what payment level.

How do I file a claim?

Claim forms are available from your human resources department or can be downloaded and printed out from MetLife's dental website at www.metlife.com/dental. Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a participating PDP dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1-800- ASK - 4 - MET after your plan's effective date.

Dental Claims Address: MetLife Dental Claims, P.O. BOX 981282,
El Paso, TX 79998-1282

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?

Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

Lincoln Financial Group®

Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: Dorse & Company, Inc.

All Active Full-time Owners

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

Eligibility	All full-time active employees working 20 or more hours per week in an eligible class are eligible for coverage on the policy effective date.
Maximum Monthly Benefit	60% of salary up to $10,000 per month
Maximum Benefit Duration	Later of Age 65 or Social Security Normal Retirement Age
Elimination Period	90 days The number of days you must be disabled prior to collecting disability benefits.
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability. If you are working on a partial basis, you will have 2x the elimination period days to satisfy the total of 90 days.
Pre-Existing Condition	No treatment for 3 months prior to the coverage effective date unless it begins after you have performed your regular occupation on a full-time basis for 12 months following the coverage effective date.
Enrollment	You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Survivor Income Benefit	A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.
***EmployeeConnect*SM**	Access to an employee assistance program for the employee or an immediate household family member who may be experiencing personal or workplace issues.
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit
Conversion	If you terminate your employment, you may be able to convert this policy.

Understanding Your Benefits	
Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within six months of returning to work, you will begin receiving benefits again immediately.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act or war, or participation in a riot.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings the insured earns or receives from any form of employment. • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), **which is not licensed and does not solicit business in New York**. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. **Each affiliate is solely responsible for its own financial and contractual obligations.**

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.

DORSE & COMPANY EMPLOYEE BENEFITS
BENEFITS, COMPLIANCE & NOTIFICATION SHEET

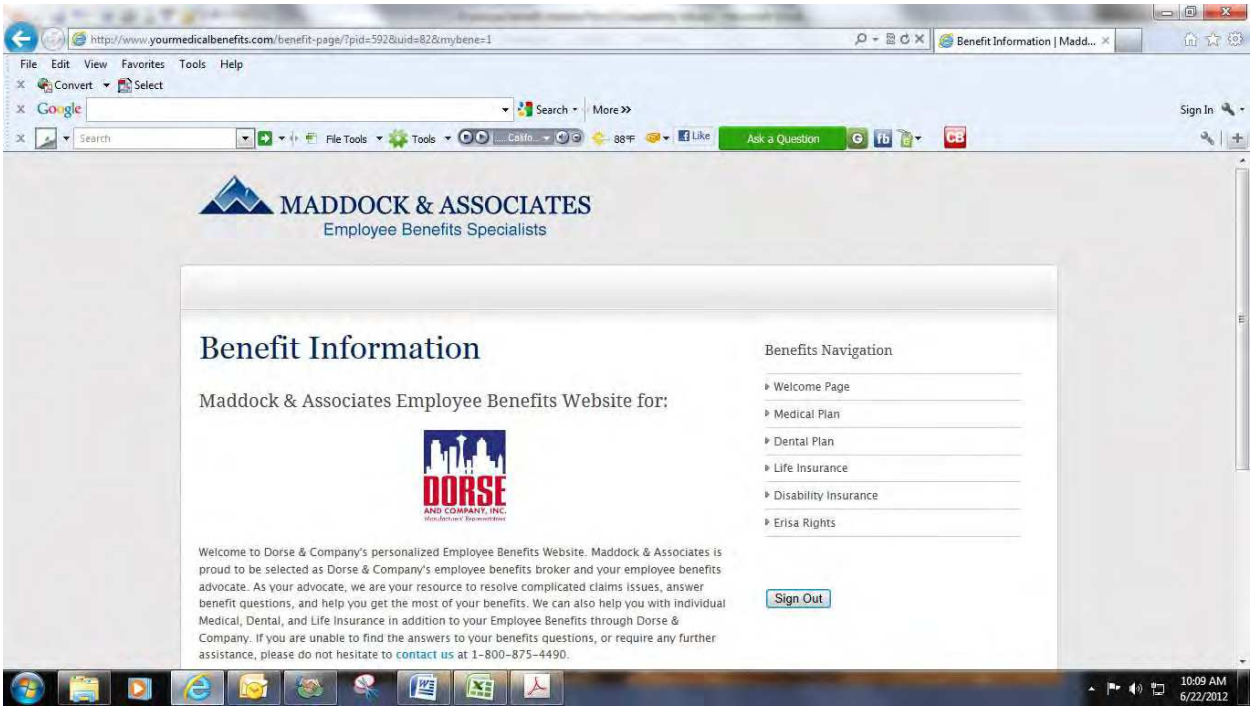
Below is a list of rights and notices that apply to you through the Dorse & Company Employee Benefit plan. Please visit www.yourmedicalbenefits.com to download details about this important information. The log in and password are on the first page of this packet. Paper copies are available upon request 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
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™ Washington Alliance for Health Insurance Trust

NWtech
Northwest Technologies Employee Benefits Program

EMPLOYEE MEDICAL/DENTAL ENROLLMENT APPLICATION

W/_____

ENROLLMENT INFORMATION:		★ Effective Date of Enrollment or Change ➔	/ 01 /

Reason for Enrollment (Check One)
- ❑ Open Enrollment (new or renewing groups)
- ❑ New Hire or new to Eligible Class
- ❑ COBRA / Continuation - start date ____/____/____
- ❑ Add Dependent(s) (Specify qualifying event at right)
- ❑ Special Enrollment (Specify qualifying event at right)

Qualifying Event
- ❑ Involuntary Loss of Coverage
- ❑ Medical Assistance/CHIP
- ❑ Court Order (Dep. Child)
- ❑ Birth
- ❑ Marriage/Domestic Partnership (DP) Date of marriage or DP _____/_____/_____
- ❑ Adoption/Legal Guardian (Legal Documents Required)

Reason for Change
- ❑ Name Change
- ❑ Address Change
- ❑ Beneficiary Change

Note: To terminate employee or dependent coverage, use billing statement, SIMON or email to customerservice@bsitpa.com

EMPLOYER INFORMATION: (To be completed by the employer) (★ indicates mandatory field) PLEASE REVIEW FOR ACCURACY BEFORE SUBMITTING

★Employer Name		★Employee's Date of Hire	/ /	Date Employee entered eligible class (if different than Date of Hire)	/ /
Class (If Applicable)	❑ Class 1	❑ Class 2		❑ Class 3	

Employee's Medical Plan Selection (If Applicable)

❑ Wellness 1	❑ GF Choice 2	❑ GF Choice 4	❑ Solutions 1000	❑ Solutions 2500	❑ Secure 500	❑ GF Secure 1000	❑ Secure 2500	❑ HSA 2000
❑ Wellness 2	❑ Choice 3	❑ Solutions 500	❑ GF Solutions 1000	❑ Solutions 3000	❑ GF Secure 500	❑ Secure 1500	❑ Secure 3000	❑ GF HSA 2000
❑ Choice 1	❑ GF Choice 3A	❑ GF Solutions 500	❑ Solutions 1500	❑ Solutions 4000	❑ Secure 750	❑ GF Secure 1500	❑ Secure 4000	❑ HSA 3000
❑ GF Choice 1	❑ GF Choice 3B	❑ Solutions 750	❑ GF Solutions 1500		❑ GF Secure 750	❑ Secure 2000		❑ GF HSA 3000
❑ Choice 2	❑ Choice 4	❑ GF Solutions 750	❑ GF Solutions 2000		❑ Secure 1000	❑ GF Secure 2000		

EMPLOYEE INFORMATION: (To be completed by the Employee) (★ indicates mandatory field) PLEASE PRINT CLEARLY

★First Name	Middle	★Last Name	Suffix (Jr, Sr, etc.)	Phone ( )	★Employee's Birth Date / /	★Gender ❑ Male ❑ Female

★Mailing Address	★City	★State	★Zip	Marital Status	★Social Security # – –	Annual Salary (for Salary-Based Life)

Employee's Prior Coverage Information

Enrollees who have been covered by health insurance during the 3 calendar months prior to enrolling in this plan must provide information below:

Date Prior Coverage Began	Date Prior Coverage Ended	Name of Prior Insurance Company

CONTINUE TO PAGE 2

Revised February 2012 for Groups with effective dates of July 1, 2012 through June 1, 2013

019740 (07-2012)

EMPLOYEE MEDICAL/DENTAL ENROLLMENT APPLICATION

W/_____

Employer Name:		*Employee Name:*	

DEPENDENT INFORMATION:

To enroll a dependent(s) provide information below. If you have more than five dependents, please attach a second form. If a dependent wishes to waive either dental or medical, check the appropriate box below. If any of your dependents had health insurance coverage during the prior 3-month period before their enrollment date on this plan, please be certain to provide PRIOR COVERAGE information. Changes in dependent coverage must comply with the rules governing the Trust, including Qualifying Events as outlined in your benefit booklet.

IMPORTANT! Covered dependents may waive Dental or Medical. Please check below the coverage they wish to **WAIVE**. If waiving both, the *Waiver of Coverage Form* should be used and dependent information is not needed on this form.			★**Birth Date** (Child over-age 25 requires certification)	★**Relationship** (Spouse, Domestic Partner, Son, Daughter)	★**Gender** Circle One	★**Social Security #**	**Prior Coverage Information**		
WAIVE Medical	**WAIVE** Dental	★**Name of Spouse/Dependent** (If spouse/dependent has different mailing address, please attach) First Last					**Covered under what subscriber's name?**	**Date Coverage Began**	**Date Coverage Ended**
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /

BENEFICIARY FOR EMPLOYEE'S BASIC LIFE / AD&D INSURANCE BENEFIT:	Beneficiary Name	Beneficiary Address	Relationship

I hereby apply for enrollment or change of enrollment as indicated on Page 1 and 2 of this application. I understand that WAHIT may collect, use and disclose protected health information for eligibility purposes. The Carriers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other payers, underwriting and conducting case management care management and quality reviews. WAHIT and the Carriers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. It is a crime to knowingly provide false, incomplete, or misleading information to a carrier for the purposes of defrauding the carrier. Penalties include imprisonment, fines and denial of coverage.

★Employee Signature	Employee's Email Address (Required for web access)	★Date

Employee eligibility will not be forwarded to the carrier and service providers without employee signature. Please return this form to your employer.

Medical and Dental Plans underwritten by Premera Blue Cross, 7001 220th SW Mountlake Terrace, WA 98043; Life Plans by LifeWise Assurance Company, 7007 220th SW, Mountlake Terrace, WA 98043; Vision plans by Vision Service Plan, 600 University St. Ste. 2004, Seattle, WA 98101; EAP by ComPsych Corporation, 455 N Cityfront Plaza Dr, Chicago, IL 60611. Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

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WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST
WAIVER OF COVERAGE FORM

This is to confirm that I decline to participate in the programs offered through my employer's group health plan as follows:

- ❑ I do not wish to enroll **myself.** I have other health care coverage.
- ❑ I do not wish to enroll **myself.** I do not have other health care coverage.
- ❑ I do not wish to enroll my ❑ **spouse** ❑ **child(ren).** They have other health care coverage.
- ❑ I do not wish to enroll my ❑ **spouse** ❑ **child(ren).** They do not have other health care coverage.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption. See your medical plan booklet for more details.

Employee Name: _____ Employee Signature: _____

Employer Name: _____

Date: _____

Enrollment Form for Group Insurance

Metropolitan Life Insurance Company

SBC Administration
P.O. Box 14593, Lexington, KY 40512-4593

MetLife®

Employee Name (Last, First, Middle)	*Social Security Number*	*Customer Number*	*Division*	*Class*

Your Home Address *City* *State* *ZIP*	*Sex (M/F)*	*Date of Birth*	*Marital Status*
			☐ *Single* ☐ *Married*

Your Occupation	*Employer Name*	*Worksite Zip Code*	*Hire Date*	*Hours Worked Per Week*	*Salary: $ _____* ☐ *Annual* ☐ *Monthly* ☐ *Hourly*

Reason for Enrollment:

☐ First Time Eligible
☐ Change in Insurance Amount Requested
☐ COBRA - Original COBRA Eff. Date _____ # of Mos. _____
☐ Late Enrollee
☐ Change in Enrollment Other Than Insurance Amount

Dental Coverage Requested:

☐ **Employee Coverage**
☐ **Spouse Coverage**
☐ **Child(ren) Coverage**

If applying for Dependent Coverage (Spouse and Child), complete section below:
Number of dependents (including spouse) _____

Name (Last, First, MI)	*Date of Birth*	*Sex (M/F)*
Spouse		
Child(ren)		

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	*Name of School*	*# of Hours*

To decline coverage, complete this section:
I understand that I have been given the opportunity to participate in the group insurance plan offered by my Employer. I am refusing the coverage(s) indicated at the right for which I am required to contribute. For Dental Insurance, a waiting period may be required for certain services before expenses will be payable.

	Employee	Spouse	Child
Dental	☐	☐	☐

Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other):

_____

DECLARATION SECTION -- TO BE COMPLETED BY THE EMPLOYEE

The Employee signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. The Employee understands that this information will be used by MetLife to determine insurability.

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

New York [only applies to Accident and Heath Insurance (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

All other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Payroll Deduction Authorization by the Employee

I authorize my Employer to deduct the required contributions from my pay for the insurance requested in this enrollment form. This authorization applies to such insurance until I rescind it in writing.

_____ _____

Employee Signature (The employee must sign in all cases.) Date (Month/Day/Year)

Michigan Residents ONLY *– Sign Below* ***if Employee is enrolling for Dependent insurance on Page 1***

_____ _____

Proposed Dependent age 18 or older Date (Month/Day/Year)

_____ _____

Proposed Dependent age 18 or older Date (Month/Day/Year)

New York Residents ONLY – If enrolling stephchild(ren) for Dependent insurance on Page 1, the natural parent must sign:

_____ _____

Signature of Natural Parent (if different from employee signature above) Date (Month/Day/Year)

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

OFFICE CODE:	Memo

Please Use Ink or Type | GROUP ID: | GROUP POLICY #:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)	County	State

Social Security Number	Last Name	First Name	MI

Street Address	City	State	Zip	Date of Birth

☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone ( )	Work Phone ( )

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:

Earnings: $_____
☐ Hourly ☐ Monthly
☐ Weekly ☐ Yearly

☐ Union ☐ Exempt
☐ Non-Union ☐ Non-Exempt

Average Hours Worked Per Week:

Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Basic Amount *Employer to Complete*	**NOTE**: Please mark each box if you are eligible for the listed coverage. Coverage	Amount	Dental
			Group Life ☐ Yes ☐ No		☐ Single Dental
			Group AD&D ☐ Yes ☐ No		☐ EE/Spouse
			Dependent Life ☐ Yes ☐ No		☐ EE/Spouse/Children
			Optional Employee Life ☐ Yes ☐ No		☐ EE/Children ☐ One Child ☐ 2 or More Children
			Optional Dependent Life ☐ Yes ☐ No		☐ No Coverage
			Optional AD&D ☐ Yes ☐ No		
			Long Term Disability ☐ Yes ☐ No		Effective:_____
			Short Term Disability ☐ Yes ☐ No		

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number

Street Address	City	State	Zip

Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number

Street Address	City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

D. Signature (Complete for ALL Enrollments)

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

_____
Employee Signature

_____
Date Signed

Dental Enrollment is on the back of this Enrollment Form.

Waiver of Coverage: Please sign and date this form where indicated below.

Please Use Ink or Type | GROUP ID:

E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan? ☐ Yes ☐ No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan? ☐ Single ☐ Family

F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:

(Please indicate your choice)
- ☐ (a) not to enroll myself or dependents in the Program
- ☐ (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

Employee Signature _____ Date Signed _____

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.