Medical Plans for 2023

The slides in this presentation are intended to be an overview of your benefits. If there are any discrepancies between the terms described in this presentation and the terms in the actual benefit plan documents, the official Plan Documents will take precedence.

MEDICAL | PLAN 1 $2,500 PPO

United Healthcare

IN-NETWORK BENEFITS	Single	Family
Calendar Year Deductible (Embedded)	Preventative Care Paid at 100% $2,500	$5,000
Coinsurance Limit	80% / 20%	
Primary Care Visit	$15 Copay	
Specialty Care Visit	$50/$100 Copay Designated Network/Network	
Urgent Care Visit	$25 Copay	
Emergency Room Visit	$300 Copay Plus Deductible + 20% Co-Insurance	
Prescription Drug 30 Day Supply 90 Day Supply	 $10 / $40 /$85/ $250 $25 / $100 / $213 / $625	
Calendar Year Max Out-Of-Pocket	$7,150	$14,300

MEDICAL | PLAN 2 $5,000 PPO

United Healthcare

IN-NETWORK BENEFITS	Single	Family
Calendar Year Deductible (Embedded)	Preventative Care Paid at 100% $5,000	$10,000
Coinsurance Limit	80% / 20%	
Primary Care Visit	$15 Copay	
Specialty Care Visit	$50/$100 Copay Designated Network/Network	
Urgent Care Visit	$25 Copay	
Emergency Room Visit	$300 Copay Plus Deductible + Co-Insurance	
Prescription Drug 30 Day Supply 90 Day Supply	 $10 / $40 / $85 / $250 $25/ $100 / $213 / $625	
Calendar Year Max Out-Of-Pocket	$7,150	$14,300

MEDICAL | PLAN 3 $5,000 HSA

United Healthcare

IN-NETWORK BENEFITS	Single	Family
Calendar Year Deductible (Embedded)	Preventative Care Paid at 100% $5,000	 $10,000
Coinsurance Limit	100%	
Primary Care Visit	Deductible + $25	
Specialty Care Visit	Deductible + $50	
Urgent Care Visit	Deductible + $75	
Emergency Room Visit	Deductible + $250	
Prescription Drug 30 Day Supply 90 Day Supply	Rx after deductible $10 / $40 / $85 / $250 $25/ $100 / $213 / $625	
Calendar Year Max Out-Of-Pocket	$6,650	$13,300

HEALTH SAVINGS ACCOUNTS

An HSA is a Healthcare Savings Account offered exclusively to enrollers of the high-deductible health plan (Plan 3). All funds contributed into an HSA are yours and will remain in your bank account until you spend them, though you must be actively enrolled in the company HDHP to contribute into the account.

To be eligible for the HSA Account, you cannot be enrolled in Medicare OR have a balance in an FSA account.

	Individual	Family
2023 Contribution Maximum (Employer & Employee)	$3,850 Increased $200	$7,750 Increased $450

If you reach age 55 or older before the end of the year, you may make additional "catch-up" contribution of a $1,000

2023 Premiums

Employee Contributions

MEDICAL | Your Costs

PREMIUMS – Per Pay (Weekly)	PPO – Option 1	PPO – Option 2	HDHP- Option 3
Employee Only	$46.08	$31.41	$20.88
Employee + Spouse	$201.02	$168.74	$145.57
Employee + Children	$149.38	$122.96	$104.01
Employee + Family	$304.31	$260.29	$228.70

DENTAL | Principal

IN-NETWORK BENEFITS	MAC Plan	UCR Plan
CALENDAR YEAR DEDUCTIBLE -Single -Family	 $50 $150	 $50 $150
ANNUAL MAXIMUM	$1,000	$1,000
PREVENTIVE SERVICES	100% Covered	100% Covered
BASIC SERVICES	Negotiated Fee Schedule 100%	90th Percentile 80%
MAJOR SERVICES	60%	50%

*Annual Maximum Rollover Benefit	
Rollover Threshold	$500
Rollover Amount	$250
Rollover In-Network	$350
Rollover Account Limit	$1,000

Employee Cost Weekly	
Employee Only	$5.46
Employee + Spouse	$11.08
Employee + Child(ren)	$13.57
Family	$20.44

Dependent Age Limit: 26 → The end of the calendar month of the 26th birthday.

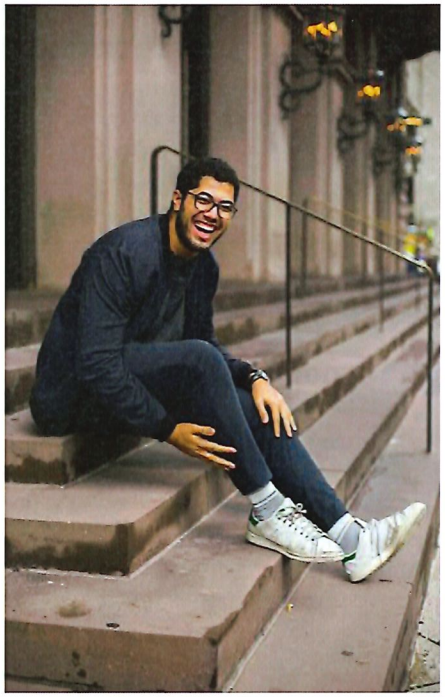
Please refer to your Summary of Benefits and/or Certificate of Coverage for specific benefit details.

VISION | Principal

BENEFIT FREQUENCIES	VSP VISION
Examination	12 months
Lenses	12 months
Frames	24 months
VISION EXAM	$10 copay
LENSES & FRAMES	
Lenses	Single Vision: $25 copay Bifocals: $25 copay Trifocals: $25 copay
Frames	$150 allowance
CONTACTS	Elective: $150 allowance

Benefits available for LENSES may be used for CONTACT LENSES in lieu of LENSES.

Dependent Age Limit: 26 → The end of the calendar month of the 26th birthday.



Employee Cost Weekly	
Employee Only	$1.37
Employee & Spouse	$2.97
Employee & Child	$3.01
Family	$4.93

Please refer to your Summary of Benefits and/or Certificate of Coverage for specific benefit details.

VOLUNTARY LIFE | Principal

	Employee	Spouse	Child(ren)
Benefit Options	$10,000	$5,000	
Coverage Amount Maximum	$300,000	$100,000	$5000 or 10,000
Guarantee Issue	$150,000 under 70	$30,000	N/A

You will be required to add a Beneficiary!

Remember to complete an EOI form if electing over the GI or enrolling as a late entrant!