MEDICAL | PLAN 1 $2,500 PPO

MEDICAL MUTUAL®

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	$30 Copay	
Specialty Care Visit	$60 Copay	
Urgent Care Visit	$75 Copay	
Emergency Room Visit	$350 Copay + 20% Co-Insurance	
Prescription Drug 30 Day Supply 90 Day Supply	 $10 / $40 /$80/ 25% to $350 $25 / $120 / $240 / 25% to $350	
Calendar Year Max Out-Of-Pocket	$6,000	$12,000

MEDICAL | PLAN 2 $5,000 PPO

MEDICAL MUTUAL®

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	$30 Copay	
Specialty Care Visit	$60 Copay	
Urgent Care Visit	$75 Copay	
Emergency Room Visit	$350 Copay + 20% Co-Insurance	
Prescription Drug 30 Day Supply 90 Day Supply	 $10 / $40 /$80/ 25% to $350 $25 / $120 / $240 / 25% to $350	
Calendar Year Max Out-Of-Pocket	**$7,350**	**$14,700**

MEDICAL | PLAN 3 $5,000 HSA

MEDICAL MUTUAL®

IN-NETWORK BENEFITS	Single	Family
Calendar Year Deductible (Embedded)	**Preventative Care Paid at 100%** $5,000	$10,000
Coinsurance Limit	100%	
Primary Care Visit	$30 after Deductible	
Specialty Care Visit	$60 after Deductible	
Urgent Care Visit	$75 after Deductible	
Emergency Room Visit	$400 after Deductible	
Prescription Drug	**Rx after deductible**	
30 Day Supply	$0 / $35 / $70 / 25% up to $350	
90 Day Supply	$0/ $105 / $210 / 25% up to $350	
Calendar Year Max Out-Of-Pocket	**$6,500**	**$13,000**

MEDICAL | Your Costs **NO INCREASE!**

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

Dependent Age Limit: 26 (end of month)

DENTAL | Principal

IN-NETWORK BENEFITS		MAC Plan	UCR Plan
DEDUCTIBLE	–Single -Family	$50 $150	$50 $150
PREVENTIVE		100% Covered	100% Covered
BASIC		Negotiated Fee Schedule 100%	90th Percentile 80%
COMPLEX		60%	50%
ANNUAL MAXIMUM		$1,000 + max rollover	$1,000 + max rollover

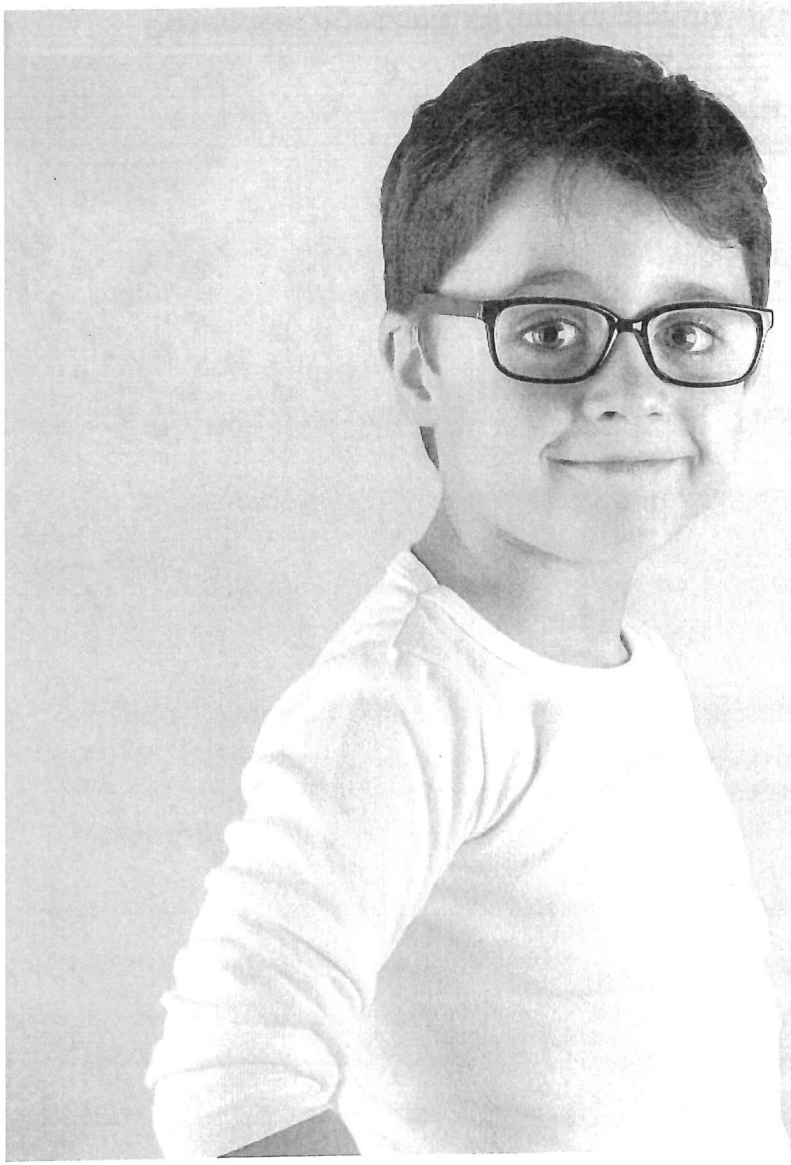
Annual Maximum Rollover Benefit

Threshold	$500	In-Network	$350
Rollover Amount	$250	Account Limit	$1,000

Employee Weekly Cost

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

ONEDIGITAL



VISION | Principal

BENEFIT FREQUENCIES	VISION
Examination	12 months
Lenses	24 months
Frames	24 months
VISION EXAM	$10
Lenses	Single Vision: $25 copay Bifocals: $25 copay Trifocals: $25 copay
Frames	$150 allowance
CONTACTS	Cosmetic: $150 allowance

Employee Weekly Cost

Employee Only	$1.37	Employee Child(ren)	$3.01
Employee + Spouse	$2.97	Family	$4.93

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.

VOLUNTARY LIFE | Principal

	Employee	Spouse	Child(ren)
Election Increments	$10,000	$5,000	$5,000
Coverage Maximum	$300,000	$100,000	$10,000
Guaranteed Issue	$150,000 **Under 70**	$30,000	

Open Enrollment Rules

- ✓ **Those currently enrolled under the Guarantee Issue can increase up to $20K**
- ✓ **Those currently enrolled and over the Guarantee Issue amount, can increase up to $20k up to the plan max**
- ✓ **Those that have never enrolled can elect $10k-$20k without a statement of health**
- ✓ **The spouse can increase $5k-$10k even if the employee doesn't, not to exceed 100% of the employee's amount**
- ✓ **The child benefit can be added or increased**

A statement of health *may* be required, these will be mailed or emailed to you.

You will be required to add a Beneficiary!