

DO YOU KNOW ABOUT EMPLOYEE & COVERED FAMILY MEMBER'S BENEFITS

CONTRIBUTION RATE OF \$4.25 - \$4.49 EFFECTIVE 1/1/19

	I Less than 14 hours Per week	II 15 hours to Less than 24 hours Per week	III 25 hours to Less than 34 hours Per week	IV 35 hours or more Per week
Employee Death Benefit	\$750.00	\$1,500.00	\$3,000.00	\$4,500.00
Employee AD&D	\$750.00	\$1,500.00	\$3,000.00	\$4,500.00
Employee Weekly A&S	\$40.00	\$60.00	\$80.00	\$100.00
Employee's Survivor Death Benefit Provisions	\$100.00 x 3 months	\$150.00 x 3 months	\$200.00 x 3 months	\$300.00 x 3 months

Single Employees will have an additional \$1,000.00 death benefit.

◆ **WEEKLY ACCIDENT AND SICKNESS (A & S) BENEFIT:** Payments are made to employees when they are disabled by a non-occupational accident or sickness. Payments begin 1st day for accident, 4th day for sickness, for a maximum of 6 weeks.

EMPLOYEE AND COVERED FAMILY MEMBER'S MEDICAL BENEFITS CLASSIFICATION

	I Less than 14 hours per week	II 15 hours to Less than 24 hours per week	III 25 hours to Less than 34 hours per week	IV 35 hours or more per week
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	\$700	\$700	\$650	\$650
FAMILY CALENDAR YEAR DEDUCTIBLE	\$1,400	\$1,400	\$1,300	\$1,300
EMERGENCY ROOM (COPAY) waived if admitted to hospital	\$300	\$300	\$300	\$300
FUND PAYS In-Network (PPO) after deductible is met	70%	70%	70%	70%
PARTICIPANT PAYS In-Network (PPO)	30%	30%	30%	30%
FUND PAYS (Out of PPO Network) after deductible is met	60%	60%	60%	60%
PARTICIPANT PAYS (Out of PPO Network)	40%	40%	40%	40%
INDIVIDUAL OUT OF POCKET MAXIMUM	\$4,800	\$4,800	\$4,800	\$4,800
FAMILY OUT OF POCKET MAXIMUM	\$9,600	\$9,600	\$9,600	\$9,600
INDIVIDUAL PHARMACY OUT OF POCKET MAXIMUM	\$2,550	\$2,550	\$2,550	\$2,550
FAMILY PHARMACY OUT OF POCKET MAXIMUM	\$5,100	\$5,100	\$5,100	\$5,100
INDIVIDUAL PHARMACY DEDUCTIBLE	\$275	\$225	\$200	\$175
FUND PAYS (after deductible is met)	70%	70%	70%	70%
PARTICIPANT PAYS	30%	30%	30%	30%
DENTAL BENEFIT EMPLOYEE	\$350	\$450	\$650	\$850
DENTAL BENEFIT DEPENDENT	\$175	\$225	\$325	\$425
INDIVIDUAL DENTAL DEDUCTIBLE	\$225	\$175	\$150	\$125
VISION BENEFIT EMPLOYEE ONLY (every 24 months)	\$100	\$150	\$200	\$250

Primary Care Physician means: General Practitioner, Internist, Family Practice Physician, and Pediatrician

Any services performed in or outside the Physician's office are subject to the Calendar Year Deductible and then paid at 70% in-network or 60% out of network. One family member must meet the first Out of Pocket Maximum and combined family members must meet the second Out of Pocket Maximum. Fund pays 100% of medical expenses after deductibles and coinsurance have been met.

BIRTH CONTROL PRESCRIPTIONS & DEVICES: 100% of eligible charge for female employees and spouses.

DENTAL BENEFITS: Participant pays the deductible. The fund then pays 70% of the covered charges up to the calendar year maximum. Prosthetic devices and services have a 12-month waiting period and are paid at 45% of covered charges up to the calendar year maximum. Orthodontic services and supplies are not a covered benefit.

MATERNITY is treated as any other illness for female employees and spouses.

ELIGIBILITY PERIOD: Employees become eligible for the benefits outlined above after completion of 30 days employment.