

**DO YOU KNOW ABOUT EMPLOYEE & COVERED FAMILY MEMBER'S BENEFITS**  
**CONTRIBUTION RATE OF \$4.40 AND ABOVE EFFECTIVE 7/1/17**

	<b>I</b> Less than 14 hours Per week	<b>II</b> 15 hours to Less than 24 hours Per week	<b>III</b> 25 hours to Less than 34 hours Per week	<b>IV</b> 35 hours or more Per week
Employee Death Benefit	\$1,000.00	\$2,000.00	\$3,500.00	\$5,000.00
Employee AD&D	\$1,000.00	\$2,000.00	\$3,500.00	\$5,000.00
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**

	<b>I</b> Less than 14 hours per week	<b>II</b> 15 hours to Less than 24 hours per week	<b>III</b> 25 hours to Less than 34 hours per week	<b>IV</b> 35 hours or more per week
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	\$400	\$400	\$350	\$350
FAMILY CALENDAR YEAR DEDUCTIBLE	\$800	\$800	\$700	\$700
FUND PAYS In-Network (PPO) <b>after deductible is met</b>	75%	75%	75%	75%
PARTICIPANT PAYS In-Network (PPO)	25%	25%	25%	25%
FUND PAYS (Out of PPO Network) <b>after deductible is met</b>	65%	65%	65%	65%
PARTICIPANT PAYS (Out of PPO Network)	35%	35%	35%	35%
INDIVIDUAL OUT OF POCKET MAXIMUM	\$3,500	\$3,500	\$2,500	\$2,500
FAMILY OUT OF POCKET MAXIMUM	\$7,000	\$7,000	\$5,000	\$5,000
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	\$250	\$200	\$175	\$150
FUND PAYS ( <b>after deductible is met</b> )	70%	70%	70%	70%
PARTICIPANT PAYS	30%	30%	30%	30%
DENTAL BENEFIT EMPLOYEE	\$400	\$600	\$800	\$1,000
DENTAL BENEFIT DEPENDENT	\$200	\$300	\$400	\$500
INDIVIDUAL DENTAL DEDUCTIBLE	\$200	\$150	\$125	\$100
VISION BENEFIT EMPLOYEE ONLY ( <b>every 24 months</b> )	\$150	\$200	\$250	\$300

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

Any services performed in the Physician's office are covered at 100% after the copayment. Services performed outside of the Physician's Office are subject to the Calendar Year Deductible and then paid at 75% in-network or 65% 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, copays 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 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.