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

CONTRIBUTION RATE OF $4.40 AND ABOVE EFFECTIVE 1/1/18

	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	$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

	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
INDIVIDUALCALENDAR YEAR DEDUCTIBLE	$650	$650	$600	$600
FAMILY CALENDAR YEAR DEDUCTIBLE	$1,300	$1,300	$1,200	$1,200
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	$4,500	$4,500	$4,500	$4,500
FAMILY OUT OF POCKET MAXUMUM	$9,000	$9,000	$9,000	$9,000
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 (**after deductible is met**)	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 (**every 24 months**)	$150	$200	$250	$300

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 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.

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