

2016 Health Plan Summary

CHOICE PLAN & HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Service	Choice Plan	High Deductible Health Plan (HDHP)		
Deductible	\$1,000 single \$2,000 more than one covered member	\$3,500 single \$7,000 more than one covered member		
Office Visit Co-Pay	\$30 Primary Care \$40 Specialty Care	Plan pays 100% AFTER deductible has been met		
Emergency Room Co-pay	\$350/visit	Plan pays 100% AFTER deductible has been met		
Preventive Care	Covered 100%	Covered 100% - deductible waived.		
Co-Insurance	Plan pays 80% / Employee pays 20% after deductible is met	Plan pays 100% after deductible has been met		
Out of Pocket Maximum (after deductible is met for Choice)	\$4,500 Network single + deductible = \$5,500 \$9,000 for more than one member + deductible = \$11,000 Unlimited Out of Network	\$3,500 Network/\$7,000 Out of Network for single \$7,000 Network/\$14,000 Out of Network for more than one covered member		
All Co-pays are included in Out of Pocket Max				
Prescription Coverage (included in health plans)	Retail (30 day supply)	Mail Order (90 day supply)	Retail (30 day supply)	Mail Order (90 day supply)
	\$10 Generic	\$20 Generic	Plan Pays 100% after deductible has been met	Plan Pays 100% after deductible has been met
	\$30 Brand	\$60 Brand		
	\$60 Non-preferred	\$120 Non-preferred		
Generic Incentive: This plan requires the use of generic unless you pay the retail difference between the generic and brand name drug.				

At the EWC preventative care is free, acute visits if you are enrolled in the HDHP will have a \$20 co-pay. Flex/HSA debit cards can be used.

RATES - All Rates are bi-weekly rates

Benefit Type	Single		Employee/Spouse		Employee/Child(ren)		Family	
	Choice	HDHP	Choice	HDHP	Choice	HDHP	Choice	HDHP
Full-Time	\$75.23	\$66.46	\$150.46	\$137.08	\$121.85	\$114.00	\$198.00	\$184.15
Part-Time	\$188.54	\$166.38	\$377.08	\$342.69	\$305.31	\$285.23	\$495.69	\$460.38
Retiree	\$817.00	\$735.42	\$1,634.00	\$1,485.00	\$1,323.00	\$1,236.00	\$2,149.00	\$1,995.00

Health Savings Account Employer contributions

Benefit Type	Single		Employee/Spouse		Employee/Child(ren)		Family	
	Per Paycheck	Annually	Per Paycheck	Annually	Per Paycheck	Annually	Per Paycheck	Annually
	\$14.48	\$362.00	\$28.80	\$720.00	\$16.80	\$420.00	\$29.76	\$744.00

IRS maximum contributions for HSA's for 2016 (amounts must include employer contributions above):

Single - \$3,350 annually
Family - \$6,750 annually

***Note:** Open Enrollment is not optional. You must complete the Open Enrollment process through Infinity even if you are not changing benefits. The Open Enrollment window is November 5, 2015 through November 19, 2015.

www.infinityhr.com (the user ID is your employee number)

2016 Dental Summary

All Rates are bi-weekly rates and based on 26 paychecks per year

Dental Plan	Alpha Dental Plan			Care POS (Point of Service)			Self-funded Delta Plan A			Self-funded Delta Plan B		
Description												
Deductible	None			None			\$25/year, \$75/year family deductible			\$25/year, \$75/year family deductible		
Co-insurance	None			None			100% Preventive, 80% Basic Care (fillings simple extractions), 50% Other Covered Services			100% Preventive, 100% Basic Care (fillings simple extractions), 50% Other Covered Services		
Benefits	Refer to fee schedule – Receive up to 100% discount for preventative care, up to 80% for basic care, up to 60% for major. Average discount is approximately 65% on all dental procedures.			Refer to fee schedule – Receive up to 100% discount for preventative care, up to 80% for basic care, up to 60% for major. Average discount is approximately 53% on all dental procedures.			Not applicable			Not applicable		
Annual Benefit Maximum	No limit (use as much as you like)			No limit (use as much as you like)			\$1,000 per covered individual (Preventive care does NOT go towards annual maximum)			\$1,500 per covered individual (preventative care does NOT go towards annual maximum)		
Ortho Coverage	Adult and child. Up to 23% discount (or \$1,364) on normal full fees.			Adult and child. Up to 20% discount on normal full fees.			No coverage			\$1,000 lifetime benefit per individual (adult & child coverage) paid at 50%. This benefit does NOT count toward annual benefit Max.		
Providers	Must use plan participating dentist.			Must use plan participating dentist.			Must use Delta Dentist Network. Out of network benefits will differ greatly.			Must use Delta Dentist Network. Out of network benefits will differ greatly.		
Rates:	FT		PT	FT		PT	FT		PT	FT		PT
Employee	\$0.00		\$0.00	\$0.00		\$0.00	\$0.00		\$7.85	\$4.15		\$12.00
Employee + 1 dependent	\$2.00		\$4.00	\$2.00		\$4.00	\$8.31		\$15.92	\$14.77		\$22.38
Employee + 2 or more dependents	\$3.00		\$6.00	\$3.00		\$6.00	\$13.38		\$26.08	\$24.92		\$37.62
Retiree	Single		+1 dep	Single		+1 dep	Single		+1 dep	Single		+1 dep
	\$12.00		\$22.00	\$12.00		\$22.00	\$25.00		\$51.00	\$34.00		\$65.00

2016 VSP Vision Summary

All Rates are bi-weekly rates and based on 24 paychecks per year

Vision Plan Description	Basic Vision Plan			Buy-up Vision Plan		
Copay	\$20.00 per person every 12 months			\$20.00 per person every 12 months		
Glasses OR Contact Lens	Not applicable			\$ 20.00 co-pay + discounts for lenses, frames or contact (see flyer for detail)		
Additional discounts	Not applicable			See flyer on COGIE or Enrollment Website for additional information		
Providers	Must use VSP plan participating provider.			Must use VSP plan participating provider.		
Rates:	FT – 3/4 - PT			FT – 3/4 - PT		
Employee	\$0.00			\$4.34		
Employee + 1 dependent	\$0.00			\$6.27		
Employee + 2 or more	\$0.00			\$11.09		
Retiree	Single	Emp + 1	Emp + 2	Single	Emp + 1	Emp + 2
	\$ 0.90	\$ 1.37	\$ 2.48	\$ 9.57	\$13.91	\$24.65