



BENEFITS OUTLINE 2018 / 2019

New hire benefits are effective date of hire

MEDICAL INSURANCE	AETNA – AET-HSA-BASE In-Network Benefits	HSA
<p>EMPLOYEE COST / MONTH</p> <p>SINGLE: \$ 39.62 DOUBLE: \$ 87.16 FAMILY: \$ 108.95</p> <p>EMPLOYER COST / MONTH</p> <p>SINGLE: \$ 306.38 DOUBLE: \$ 672.84 FAMILY: \$ 842.05</p> <p>DEDUCTIBLE</p> <p>INDIVIDUAL: \$ 2,700^ FAMILY: \$ 5,400</p>	<p>FIXED CO-PAYS (*AFTER DEDUCTIBLE)</p> <p>OFFICE VISIT (PCP): \$ NA SPECIALIST VISIT: \$ NA URGENT CARE: \$ NA ER VISIT: \$ NA AMBULANCE: \$ NA HIGH TECH IMAGING: \$ NA</p> <p>COINSURANCE MAX</p> <p>INDIVIDUAL: \$ 1,300 FAMILY: \$ 2,600</p> <p>HOSPITAL COINSURANCE 90%</p>	<p>RX CO-PAYS (*AFTER DEDUCTIBLE)</p> <p>GENERIC VALUE: \$ 3* GENERIC: \$ 10* PREFERRED BRAND: \$ 35* NON-PREFERRED BRAND: \$ 60* PREFERRED SPECIALTY: 25% MAX \$250* NON-PREFERRED SPECIALTY: 25% MAX \$250*</p> <p>TOTAL OUT-OF-POCKET MAXIMUM</p> <p>INDIVIDUAL: \$ 4,000 FAMILY: \$ 8,000</p>
<p>SPECIAL FEATURES:</p> <ul style="list-style-type: none"> • WELLNESS VISITS/CHECKUPS: Covered 100% w/ no co-pay based on gender/age guidelines • TELEDOC VIRTUAL VISITS: 24/7 phone/video physician access, including dermatology & behavioral health • INFORMED HEALTH LINE: Get your general health questions answered anytime, anywhere, 24/7 • OUT-OF-NETWORK BENEFITS: Please see individual plan summaries for details • INDIVIDUAL DEDUCTIBLE: Embedded Individual Deductible can be met before the family deductible • EMPLOYER ANNUAL HSA CONTRIBUTION: Single - \$2,700, Double & Family - \$5,400, paid evenly over plan year • EMPLOYER HRA: Employer will reimburse staff for any co-insurance cost incurred after the deductible 		

WAIVE MEDICAL BENEFIT	\$	EMPLOYER PAID
<p>SPECIAL FEATURES:</p>	<ul style="list-style-type: none"> • Staff that are eligible for but waive medical coverage will receive \$4,000 annually if eligible for single coverage, and \$6,000 annually if eligible for double or family coverage in lieu of that coverage. Waive Medical is considered taxable income. The waive medical benefit is paid evenly thru the plan year. 	

DENTAL INSURANCE	DELTA DENTAL	EMPLOYER PAID
<p>EMPLOYEE COST / MONTH</p> <p>SINGLE: \$ 0.00 DOUBLE: \$ 0.00 FAMILY: \$ 0.00</p>	<p>FEATURES</p> <p>BENEFIT MAX: \$ 1,000 DEDUCTIBLE: \$ 50 ORTHO MAX: \$ 1,000</p>	<p>DESCRIPTION</p> <p>PREVENTATIVE SERVICES: NO DEDUCTIBLE APPLIES – COVERED 100% BASIC SERVICES: COVERED 80% AFTER DEDUCTIBLE MAJOR SERVICES: COVERED 50% AFTER DEDUCTIBLE ORTHODONIC: COVERED 50% AFTER DEDUCTIBLE DEPENDENTS: COVERED TO AGE 26</p>
<p>SPECIAL FEATURES:</p> <ul style="list-style-type: none"> • No ID card required – simply let your provider know you have Delta Dental and they will be able to look you up by your SSN 		

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VISION INSURANCE		EYEMED	EMPLOYER PAID
EMPLOYEE COST / MONTH	FEATURES	DESCRIPTION	
SINGLE: \$ 0.00	EXAMS: ONCE EVERY 12 MONTHS	EXAM CO-PAY: \$ 10	
DOUBLE: \$ 0.00	CONTACTS: ONCE EVERY 12 MONTHS	CONTACT LENSES: \$130 Allowance	
FAMILY: \$ 0.00	CONTACTS: ONCE EVERY 12 MONTHS	DEPENDENTS: COVERED TO AGE 26	
	FRAMES: ONCE EVERY 24 MONTHS		
SPECIAL FEATURES: • No ID card required – simply let your provider know you have EyeMed and they will look you up by your SSN			

LIFE INSURANCE		LINCOLN FINANCIAL	EMPLOYER PAID
COVERAGE	SPECIAL FEATURES:		
EMPLOYEE: \$ 50,000	• <u>LifeKeys</u> : Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life policy.		
SPOUSE: \$ 2,000	• <u>TravelConnect</u> : Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.		
DEPENDENT: \$ 1,000			

SHORT TERM MEDICAL LEAVE		COVENANT ACADEMIES	EMPLOYER PAID
EMPLOYEE COST / MONTH	COVERAGE	SPECIAL NOTES:	
• Employer Paid	• Eligible after 1 Year of Service	• <u>STML Benefit Pay Rate</u> : Varies based on number of days taken, days:	
	• 10 day elimination period	○ 1-10: regular PTO, 100%	
	• Total Days of Paid Leave Based on Years of Service	○ 11-“X”: 100% of regular pay	
	• Max Duration of Benefits: 130 days	○ “X+1”-60: 75% of regular pay	
	• See handbook for full details	○ 61-130: 65% of regular pay	

LONG TERM DISABILITY		LINCOLN FINANCIAL - CHARTER	EMPLOYER PAID
EMPLOYEE COST / MONTH	COVERAGE	SPECIAL NOTES:	
EMPLOYEE: \$ 0.00	• 60% of weekly salary up to \$7,500 /month	• <u>Pre-Existing Condition</u> : You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under the policy until you have been covered under the policy for 12 months.	
	• Elimination Period: 180 days	• <u>Benefit Limitations</u> :	
	• Max Duration of Benefits: till age 65	– Mental Illness: 24 months	
		– Substance Abuse: 24 months	
		– Specified Illness: No Limit	

LIFE INSURANCE		LINCOLN FINANCIAL - CHARTER	VOLUNTARY EMPLOYEE PAID
EMPLOYEE COST / MONTH	COVERAGE	SPECIAL NOTES:	
• Rates are based on employee’s age and amount of coverage	EMPLOYEE: \$10k to \$200k guarantee, Max. 5X Salary or \$500k	• You must elect coverage for yourself in order to elect coverage for your spouse and / or child(ren)	
	SPOUSE: \$5k to \$30k guaranteed, Max. \$250k or 50% of Emp.	• Any amount elected over the guarantee issue amount will be subject to medical underwriting	
	DEPENDENT: \$10k guaranteed		

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SHORT TERM DISABILITY	LINCOLN FINANCIAL	VOLUNTARY EMPLOYEE PAID
<p>EMPLOYEE COST / MONTH</p> <ul style="list-style-type: none"> Rates will vary based on your weekly salary 	<p>COVERAGE</p> <ul style="list-style-type: none"> 60% of weekly salary up to \$1,000 per week Benefits begin on (Accident) 1st day Benefits begin on (Illness) 8th day Max Duration of Benefits: 26 weeks 	<p>SPECIAL NOTES:</p> <ul style="list-style-type: none"> <u>Pre-Existing Condition</u>: You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under the policy until you have been covered under the policy for 6 months.

OFF THE JOB ACCIDENT	ALLSTATE	VOLUNTARY EMPLOYEE PAID
<p>EMPLOYEE COST / MONTH</p> <p>EMPLOYEE: \$ 13.76</p> <p>EE + SPOUSE: \$ 20.85</p> <p>EE + CHILD: \$ 31.91</p> <p>EE + FAMILY: \$ 39.96</p>	<p>SPECIAL FEATURES</p> <ul style="list-style-type: none"> This coverage pays you cash benefits that correspond with a variety of covered occurrences, such as dismemberment; dislocation or fracture; hospital confinement; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more. Benefits are paid once per accident unless otherwise noted in the schedule of benefits. Guaranteed issue coverage and coverage available for spouse and child(ren). See plan document for more details. 	

HOSPITAL INDEMNITY	ALLSTATE	VOLUNTARY EMPLOYEE PAID
<p>EMPLOYEE COST / MONTH</p> <p>EMPLOYEE: \$ 7.67</p> <p>EE + SPOUSE: \$ 20.15</p> <p>EE + CHILD: \$ 13.26</p> <p>EE + FAMILY: \$ 21.84</p>	<p>SPECIAL FEATURES</p> <ul style="list-style-type: none"> This coverage pays a cash benefit for hospital confinement. This benefit is payable directly to you and can keep you from withdrawing money from your personal bank account or your Health Savings Account (HSA) for hospital-related expenses. Guaranteed issue coverage and coverage available for spouse and child(ren). Coverage can be continued as long as premiums are paid to Allstate Benefits. See plan document for more details. 	

CRITICAL ILLNESS	ALLSTATE	VOLUNTARY EMPLOYEE PAID
<p>EMPLOYEE COST / MONTH</p> <ul style="list-style-type: none"> Rates will vary based on your issue age, who you wish to cover, the amount of coverage and whether or not you use tobacco products 	<p>SPECIAL FEATURES</p> <ul style="list-style-type: none"> Benefit Coverage options are \$10,000 or \$20,000 This coverage helps offer financial support if you are diagnosed with a covered critical illness. With the expense of treatment often so high, seeking the treatment you need seems like a heavy financial burden. But when a diagnosis occurs (such as cancer, major organ failure, etc.), what you should be focusing on is getting better. With Allstate Benefits, you gain the power to take control of your health when faced with a covered event. <u>How It Works</u>: You select the benefit coverage amount you want based on your individual need and your budget. If you have covered family members, this coverage also provides cash benefits for them. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition. 	

EAP	EMPLOYEE ASSISTANCE PROGRAM	EMPLOYER PAID
<p>SPECIAL FEATURES:</p> <p>https://eaccares.com</p>	<ul style="list-style-type: none"> Provides up to five personal counseling sessions around various concerns including: <ul style="list-style-type: none"> bereavement substance abuse relationships & family 	<ul style="list-style-type: none"> child care finances various other stressors

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FINANCIAL WELLNESS	FINFIT	FREE USE OF SITE WITH REGISTRATION
<p><i>SPECIAL FEATURES</i></p> <p style="text-align: right;"><i>Access via the Axios HR Payroll website in Axios Perks</i></p>		
<ul style="list-style-type: none"> Assess your Personal Financial Health Budget Building Tools Financial Calculators Life Planning 	<ul style="list-style-type: none"> Financial Education information Online tracking of your bank accounts 24/7 Financial Wellness provided online Short-Term Loan Assistance* 	
* Fee Based Service, subject to credit approval		

PET INSURANCE	PET'S BEST	VOLUNTARY EMPLOYEE PAID
<p><u>EMPLOYEE COST / MONTH</u></p> <ul style="list-style-type: none"> Rates will vary based on an array of factors 	<p><i>SPECIAL FEATURES</i></p> <ul style="list-style-type: none"> Coverage is now available for furry family members! You are responsible for the full premium cost and are required to make direct payments to the carrier in order to maintain coverage. This plan does <u>not</u> use payroll deductions. <u>How to Enroll</u>: You will enroll directly through the carrier's website. See the plan flyer for more details. 	

FLEX BENEFIT – HEALTH & DEPENDENT CARE	AXIOS HR	VOLUNTARY EMPLOYEE PAID
<p><u>EMPLOYEE COST / MONTH</u></p> <ul style="list-style-type: none"> You elect how much to contribute annually 	<p><i>SPECIAL FEATURES</i></p> <ul style="list-style-type: none"> Health Care Spending Account Maximum Limit: \$2,650 Annually Dependent Care Spending Account Maximum Limit: \$5,000 Annually FSA's give you a way to pay for your health care and / or dependent care expenses with pre-tax dollars. FSA's are voluntary – YOU decide how much to have taken out of your paycheck and put into your Health care and / or Dependent Care Spending Account(s). See the Flexible Spending Account section for more information. 	

401(k)	JOHN HANCOCK	RETIREMENT PLAN
	SERVICE LENGTH	AGE
<p><u>ELIGIBILITY REQUIREMENTS:</u></p> <ul style="list-style-type: none"> Date of Hire 	<ul style="list-style-type: none"> Age 21 	<ul style="list-style-type: none"> Date of hire
<p><u>SPECIAL FEATURES:</u></p> <ul style="list-style-type: none"> Standard & Roth 401(k) options; over 100 mutual funds to choose from 		

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Monthly Premiums

Prism Plan Name	AET-HSA-BASE
Network	POS
Design (Trad, HRA, HSA, HBCI)	HSA
Copay Structure	HSA
Rx Tiers	5
Hospital Coinsurance	
In Network	90%
Out of Network	70%
Deductible	
Individual - In Network	\$2,700
Family - In Network	\$5,400
Individual - Out of Network	\$4,000
Family - Out of Network	\$8,000
Coinsurance Max	
Individual - In Network	\$1,300
Family - In Network	\$2,600
Individual - Out of Network	\$4,000
Family - Out of Network	\$8,000
Fixed Copays (*after deductible)	
Office Visit (PCP) Copay	90% (In) / 70% (Out) *
Specialist Copay	90% (In) / 70% (Out) *
Urgent Care Copay	90% (In) / 70% (Out) *
Emergency Room Copay	90% (In) / 70% (Out) *
Ambulance Copay	90% (In) / 70% (Out) *
High Tech Imaging	90% (In) / 70% (Out) *
Rx (*after deductible)	
Rx Value	\$3 (In) / 30% oc Cost (Out)*
Rx Generic	\$10 (In) / 30% oc Cost (Out)*
Rx Preferred Brand	\$35 (In) / 30% oc Cost (Out)*
Rx Non-Preferred Generic or Brand	\$65 (In) / 30% oc Cost (Out)*
Rx Preferred Specialty	25% Max \$250 (In) / None(Out)*
Rx Non-preferred Specialty	25% Max \$250 (In) / None (Out)*
Total Out-of-Pocket Max (in network)	
Individual - In Network	\$4,000
Family - In Network	\$8,000
Individual - Out of Network	\$8,000
Family - Out of Network	\$16,000
2018 Total Monthly Premium	
Single	\$346.00
Double	\$760.00
Family	\$951.00

Waive Medical Opt-Out

Single: \$4,000
 Double: \$6,000
 Family: \$6,000

<u>Employee current monthly cost</u>	<u>Traditional Plan Premium</u>	<u>Current HSA Contribution</u>
Single	\$79.24	\$1,250.00
Double	\$174.32	\$2,000.00
Family	\$217.90	\$2,000.00

<u>Employee new monthly cost</u>	<u>Premium</u>	<u>New HSA Contribution/ Annual</u>	<u>Per Pay</u>
Single	\$39.62	\$2,700.00	\$112.50
Double	\$87.16	\$5,400.00	\$225.00
Family	\$108.95	\$5,400.00	\$225.00

FOR REFERENCE ONLY

<u>2018-19 Priority Health Rates</u>	<u>Employee Premium</u>
Single	\$88.19
Double	\$194.02
Family	\$242.52

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