SUMMARY OF BENEFITS

Fixed Indemnity Medical Insurance Plan - Plan 1

Group Number: **3135900-BXP**

Your first option for medical coverage is the Fixed Indemnity Medical Plan. This plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits	Per Day	Plan Year Maximum	Inpatient Benefits	Per Day	Plan Year Maximum
Physician Office visit	$105	8 days	Daily Hospital Confinement	$500	3x (unlimited days)
Outpatient Surgery[1]	$1,000	1 day	Hospital Admission	$500	1 day
Anesthesia	$250	—	Intensive Care Unit Maximum[9]	$600	30 days
Diagnostic Labs[2]	$75	6 days	Skilled Nursing Facility[10]	$100	60 days (no lifetime max)
Diagnostic Tests[3]	$200	3 days	Inpatient Surgery	$2,500	1 day
Ambulance Services[4]	$300[5]/$900[6]	1 day	Anesthesia	$625	—
Emergency Room (Injuries)[7]	$500	2 days	**Wellness Care[11]**		
Emergency Room (Sickness)	$200	2 days	Persons age 1+	$100	1 Day
Prescription Drugs[8]	$20	30 days	Persons under age 1	$100	4 Days
Telemedicine Services*	No Cost	Unlimited	**Maternity Post Partum Follow-Up Care**	$25	Unlimited

*You will have access to a national Telemedicine program called 1.800MD. This program connects members to board certified physicians around the clock (24/7/365) via telephone or secure video. 1.800MD doctors can answer questions, give advice, and even diagnose and treat illnesses by calling 1-800-530-8666.

MEC Wellness/Preventive Plan

Group Number: **83135900-M-BXP**

Your second option for medical coverage is the MEC Wellness/Preventive Plan. This plan provides coverage for preventive services such as immunizations and routine health screenings.

Preventive Services Benefit	In-Network	Non-Network
Preventive Services for Adults	100%	40%
Preventive Services for Women	100%	40%
Preventive Services for Children	100%	40%

PREMIUM	Fixed Indemnity Medical Insurance Plan (Weekly)	MEC Plan (Weekly)
Employee Only	$19.98	$14.46
Employee + Child(ren)	$33.17	$20.49
Employee + Spouse	$37.96	$19.16
Employee + Family	$50.55	$25.19

[1] benefits are not payable for surgical operations performed in a Physician's office [2] routine or wellness lab screens and tests are not covered [3] laboratory tests and routine wellness screens and tests not covered [4] transportation must occur within 72 hours of the accident or onset of the sickness [5] benefit is for ground/water services [6] benefit is for air services [7] treatment must be within 72 hours of the accident [8] To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. [9] pays in addition to daily hospital confinement [10] must be under age 65 and admitted to the Skilled Nursing Facility within 14 days following a Hospital stay of at least three consecutive days [11] benefit is payable for each day an insured person has any one of the health screenings, exams, or tests listed in the policy

SUMMARY OF BENEFITS

Dental

Benefits are payable for dental treatment services and supplies performed by or prescribed by a Dentist or Dental Hygienist.

Benefits	Waiting Period/ Coinsurance	Annual Maximum Benefits: $750	Deductible: $50 (per insured person)
Coverage A	None / 80%	Exams, Cleanings, Fluoride, X-Rays, Bitewing X-rays, Tests & Labs, Space Maintainers, Emergency Treatments, and Sealants	
Coverage B	None / 60%	Fillings, Oral Surgery, Anesthesia, and Repairs for Crowns, Bridges and Dentures	
Coverage C	None / 50%	Periodontics and Endodontics Including Root Canal, Crowns, Bridges, and Dentures	

Vision

Helps offset the cost of covered procedures performed by an optometrist.

VISION BENEFIT	In-Network	Out-of-Network
Eye exam with dilation as necessary [1]	$10 Copay; plan pays 100%	Plan pays $45; you pay remaining
Exam Options		
Retinal Imaging	You pay up to $39	You pay 100% of the price
Standard Contact Lens Fit [2, 3]	You pay up to $55	You pay 100% of the price
Premium Contact Lens Fit [2, 3]	10% off retail price; you pay remaining	You pay 100% of the price
Frames [4, 5]	Plan pays 20% after $110 allowance	$90; you pay remaining
Standard Plastic Lenses [1,5, 6]		
Single Vision	$25 Copay	Plan pays $40; you pay remaining
Bifocal	$25 Copay	Plan pays $60; you pay remaining
Trifocal / Lenticular	$25 Copay	Plan pays $80; you pay remaining
Progressive–Standard	$90 Copay	Plan pays $60; you pay remaining
Progressive–Premium	$90 Copay; plan pays 20% after $120 allowance	Plan pays $60; you pay remaining
Lens Options [3]		
UV Treatment / Tint (Solid and Gradient) / Standard Plastic Scratch Coating	$15	You pay 100% of the price
Standard Polycarbonate	$40	You pay 100% of the price
Standard Anti-Reflective Coating	$45	You pay 100% of the price
Non-Glass Photochromatic / Other Add-ons and Services	20% off retail price	You pay 100% of the price
Contact Lenses [1,7]		
Conventional	$0 Copay; Plan pays 15% after $110 allowance	Plan pays $90; you pay remaining
Disposable	$0 Copay; Plan pays 100% after $110 allowance	Plan pays $90; you pay remaining
Medically Necessary	Plan pays 100%	Plan pays $210; you pay remaining
Lasik [8]	15% off retail price or 5% off promotional price	You pay 100% of the price

[1] Per insured; once every 12 months [2] Includes follow up; contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed [3] discounts are not an insured benefit and are not available for out-of-network services [4] once every 24 months [5] in lieu of contact lenses [6] 40% off additional pairs of glasses and 15% off conventional lenses once funded benefit is used [7] Contact lens allows covers materials only; in lieu of regular lenses [8] Lasik or PRK from US Laser Network

PREMIUM	Dental (Weekly)	Vision (Weekly)
Employee Only	$4.97	$1.68
Employee + Child(ren)	$11.69	$4.53
Employee + Spouse	$10.14	$3.36
Employee + Family	$18.48	$6.37