Policy Number **219301-ESG-1**

LIMITED BENEFITS SUMMARY

FIXED INDEMNITY MEDICAL BENEFIT

For more details, please see your Summary Plan Description.

The Fixed Indemnity Medical 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[1]		**Inpatient Benefits**	
Physician Office Visit	$120 per day	Standard Care	$700 per day
Diagnostic (Lab)	$200 per day	Intensive Care Unit Maximum[3]	$800 per day
Diagnostic (X-Ray)	$300 per day	Inpatient Surgery	$4,000 per day
Ambulance Services	$300 per day	Anesthesia	$800 per day
Physical, Speech, or Occupational Therapy	$75 per day	Skilled Nursing[4]	$100 per day
Emergency Room Benefit—Sickness	$200 per day	First Hospital Admission (1 per year)	$375
Emergency Room Benefit—Accident[2]	$1,000 per day	Annual Inpatient Maximum[5]	No Limit
Outpatient Surgery	$1,000 per day	**Prescription Drugs (via reimbursement)**[6, 7]	
Anesthesia	$400 per day	Annual Maximum	$700
Annual Outpatient Maximum	$2,300	Per Day	$40
Wellness Care			
Wellness Care (one per year)	$125		
Telemedicine Discount Service (phone/video)	$25 per visit		

[1]all outpatient benefits are subject to the outpatient maximum [2]covers treatment for off the job accidents only [3]pays in addition to standard care benefit [4]for stays in a skilled nursing facility after a hospital stay [5]subject to internal limits of plan [6]not subject to outpatient maximum [7]To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc.

DENTAL BENEFIT

Waiting Period/Coinsurance **Annual Maximum Benefit** $750 **Deductible** $50

Coverage A	None / 100%	Exams, Cleanings, Intraoral Films, and Bitewings
Coverage B	3 Months / 60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 Months / 50%	Periodontics, Crowns, Endodontics, Bridges and Dentures

VISION BENEFIT

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Examination [1] (including dilation)	$10 Copay	100%	100%	$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to $55 or 10% off Retail Price	$0	100%	up to $40
Frames [2]	$0 Copay, 80%, after $100 allowance	$100 allowance, 20% off	100%	$45
Standard Plastic Lenses (single, bifocal, trifocal) [1]	$10 Co-pay	20% off retail	100%	$25-$55
Lens Options	$15 Copay	-	100%	$0
Contact Lenses (Conventional) [1]	$0 Copay, 85% of remaining	$80, plus 15% off	100%	$64
Disposable Contact Lenses [1]	$0 Copay	$80 allowance	100%	$0
Medically Necessary Contact Lenses [1]	$0 Copay	100%	$0	$200

[1] Once every 12 months [2] Once every 24 months

GROUP TERM LIFE BENEFIT

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Group Term Life Benefit.)

Employee Amount	$20,000	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$20,000	**Infant Amount (15 days to 6 mos)**	$2,500

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of base pay up to $150 per week
Waiting Period/Maximum Benefit Period	7 days for injury or sickness / up to 26 weeks

LIMITED BENEFITS PREMIUM

	Medical		**Dental**		**Vision**		**Term Life**		**STD**	
	weekly	biweekly	weekly	biweekly	weekly	biweekly	weekly	biweekly	weekly	biweekly
Employee Only	$19.96	$39.92	$6.17	$12.34	$2.42	$4.84	$0.60	$1.20	$4.20	$8.40
Employee + 1	$40.51	$81.02	$12.34	$24.68	$4.92	$9.84	$0.90	$1.80	-	-
Employee + Family	$54.09	$108.18	$20.36	$40.72	$6.56	$13.12	$1.80	$3.60	-	-