# LIMITED BENEFITS SUMMARY

Policy Number **219301-ESG-1**

## FIXED INDEMNITY MEDICAL BENEFIT

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 | $100 per day | Standard Care | $300 per day |
| Diagnostic (Lab) | $75 per day | Intensive Care Unit Maximum [2] | $500 per day |
| Diagnostic (X-Ray) | $200 per day | Inpatient Surgery | $3,500 per day |
| Ambulance Services | $300 per day | Anesthesiology | $700 per day |
| Physical, Speech, or Occupational Therapy | $50 per day | Skilled Nursing [3] | $100 per day |
| Emergency Room Benefit - Sickness | $200 per day | First Hospital Admission (1 per year) | $250 |
| Emergency Room Benefit - Accident | $750 per day | Annual Inpatient Maximum [4] | No Limit |
| Outpatient Surgery | $750 per day | **Wellness Care** | |
| Anesthesiology | $300 per day | Wellness Care (one per year) | $100 |
| Annual Outpatient Maximum | $2,250 | **Prescription Drugs (via reimbursement)** [5,6] | |
| | | Annual Maximum | $600 |
| | | Per Day | $30 |

*[1] all outpatient benefits are subject to the outpatient maximum [2] pays in addition to standard care benefit [3] for stays in a skilled nursing facility after a hospital stay [4] Subject to internal limits of plan [5] not subject to outpatient maximum [6] 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, Bridges, Endodontics 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% | $0 |
| **Frames** [2] | 80%, after $110 allowance | $110, plus 20% of remaining | 100% | $55 |
| **Standard Plastic Lenses** (single, bifocal, trifocal) [1] | $10 Copay | 100% | 100% | $25-$55 |
| **Lens Options** | $15-$45 or 20% discount | 100% or 20% off retail | 100% | $0 |
| **Contact Lenses (Conventional)** [1] | $0 Copay, 85% of remaining | $110, plus 15% of remaining | 100% | $64 |
| **Disposable Contact Lenses** [1] | $0 Copay | $110, plus balance | 100% | $0 |
| **Medically Necessary Contact Lenses** [1] | $0 Copay | 100% | $0 | $200 |

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

## 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 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 Salary up to $150 per week |
| **Waiting Period/Maximum Benefit Period** | 7 days, up to 26 weeks |

| **WEEKLY LIMITED BENEFITS PREMIUM** | **Medical** | **Dental** | **Vision** | **Term Life** | **STD** |
|---|---|---|---|---|---|
| **Employee Only** | $20.25 | $6.17 | $2.42 | $0.60 | $4.20 |
| **Employee + 1** | $41.10 | $12.34 | $4.92 | $0.90 | - |
| **Employee + Family** | $54.88 | $20.36 | $6.56 | $1.80 | - |