LIMITED BENEFITS SUMMARY

Policy Number **219301-ESG-1**

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 (Virtual or In-Person)	$130 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	$350 per day	Anesthesia	$800 per day
Physical, Speech, or Occupational Therapy	$75 per day	Skilled Nursing[4]	$100 per day
Emergency Room Benefit—Sickness	$375 per day	First Hospital Admission (1 per year)	$450
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	$2,500	Per Day	$40
Wellness Care			
Wellness Care (one per year)	$125		

Teladoc Health

As an enrollee in the Fixed Indemnity medical plan, you have the option to obtain telehealth, primary care or mental health services through Teladoc Health. Please see the Summary Plan Description for additional details.

[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[3]

	In-Network	**Out-of-Network**
Eye Examination [1] (including dilation)	$10 Copay	up to $35
Exam Options (Standard or Premium Contact Lens Fit)	Up to $55 or 10% off Retail Price	up to $40
Frames [2]	$0 Copay, 20% off balance over $100 allowance	up to $45
Standard Plastic Lenses (single, bifocal, trifocal) [1]	$10 Copay	up to $25-$55
Standard Plastic Lenses (Lenticular) [1]	20% off Retail price	N/A
Other Add-Ons and Services	20% off Retail price	N/A
Lens Option (UV Coating, Tint: Solid and Gradient, Standard Scratch Resistant Coating)	$15 Copay	N/A
Standard Polycarbonate	$40 Copay	N/A
Standard Anti-Reflective Coating	$45 Copay	N/A
Premium Anti-Reflective Coating	20% off Retail Price	N/A
Standard Progressive (Add-on to Bifocal)	$75 Copay	up to $40
Premium Progressive (Add-on to Bifocal)	$75 Copay: 20% off Retail Price less $120 allowance	up to $40
Contact Lenses (Conventional) [1]	$0 Copay, 15% off balance over $80 allowance	up to $64
Disposable Contact Lenses [1]	$0 Copay, 100% off balance over $80 allowance	up to $64
Medically Necessary Contact Lenses [1]	$0 Copay	up to $200

[1] Once every 12 months [2] Once every 24 months [3]Indemnity Benefit Reduction. An Insured Person's Indemnity Benefit Amount shown above will be reduced by 50% for any benefit payable afte the Insured Person attains age 70.

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

WEEKLY LIMITED BENEFITS PREMIUM	**Medical**	**Dental**	**Vision**	**Term Life**	**STD**
Employee Only	$19.96	$6.17	$1.67	$0.60	$4.20
Employee + 1	$40.51	$12.34	$3.33	$0.90	-
Employee + Family	$54.09	$20.36	$5.28	$1.80	-

Premiums will be automatically deducted from your paycheck. For weekly payroll cycles the amount is shown above. For other payroll cycles the amount deducted will be calculated based on the weekly premium.