Carrier	Medica
Plan Name	Medica Choice Passport MN 6500-0% HSA Silver
Plan Type	PPO / HSA
Funding Type	Fully Insured
Network	CHOICE PASSPORT
Metallic Level	Silver
Referrals Required	No
In Network	
Deductible Single	$6,500
Deductible Family	$13,000
Deductible Type	Embedded
Coinsurance	100%
OOP Max Single	$6,500
OOP Max Family	$13,000
Inpatient Facility	100% after deductible
Outpatient Surgery	100% after deductible
Copays	
Office Copay	100% after deductible
Specialist	100% after deductible
Urgent Care	100% after deductible
ER	100% after deductible
Other Services	
Diagnostic Lab / X-Ray	100% after deductible / 100% after deductible
MRI & CT Scan	100% after deductible
Telemedicine	Not Covered
RX	
Rx Tiers	100% after deductible / Not Applicable / 100% after deductible / 100% after deductible / 100% after deductible
Out of Network	
Deductible Single	$10,000
Deductible Family	$20,000
Coinsurance	50%
OOP Max Single	Not Covered
OOP Max Family	Not Covered
Inpatient Facility	50% after deductible
Outpatient Surgery	50% after deductible

Medica Choice Passport MN 6500-0% HSA Silver	
Age	**Rate**
0 - 20	$406.44
21	$456.68
22	$456.68
23	$456.68
24	$456.68
25	$458.50
26	$467.63
27	$478.59
28	$496.40
29	$511.02
30	$518.32
31	$529.28
32	$540.24
33	$547.09
34	$554.40
35	$558.05
36	$561.71
37	$565.36
38	$569.01
39	$576.32
40	$583.63
41	$594.59
42	$605.09
43	$619.70
44	$637.97
45	$659.44
46	$685.01
47	$713.78
48	$746.66
49	$779.08
50	$815.62
51	$851.69
52	$891.42
53	$931.61
54	$975.00
55	$1,018.38
56	$1,065.42
57	$1,112.91
58	$1,163.60
59	$1,188.72
60	$1,239.41
61	$1,283.25
62	$1,312.02
63	$1,348.10
64 - 65	$1,370.02

- See SBC for full plan details and coverage
- Otter Express covering 75% employee premium and 25% dependent(s) premium

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,500** per person / **$13,000** per family in-network and **$10,000** per person / **$20,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers or well child and prenatal care from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,500** per person / **$13,000** per family in-network. Not applicable out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, out-of-network deductible and coinsurance.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 0% coinsurance **Chiropractic:** 0% coinsurance	**Primary:** 50% coinsurance **Chiropractic:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 0% coinsurance **X-ray:** 0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/DrugCost2	Generic drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	
	Non-preferred brand drugs	**Preventive:** Benefit does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 0% coinsurance	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	0% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	None
	Children's glasses	0% coinsurance	50% coinsurance	For members under age 19. Limited to one pair of glasses or contacts per year.
	Children's dental check-up	Not covered	Not covered	Coverage is available through a stand-alone dental policy.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child) (coverage is available through a stand-alone dental policy)
- Dental check-up
- Infertility treatment
- Long-term care
- Non-formulary drugs
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Medica at **1 (800) 952-3455** (TTY: **711**) or for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage you may also contact Medica at **1 (800) 952-3455** (TTY: **711**) or the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1 (800) 952-3455** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).

Chinese (中文): **如果需要中文的帮助，** 请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$6,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$6,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

Mia's Simple fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$6,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

Arabic/العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-952-3455 (الهاتف النصي: 711) للتواصل مع Medica، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Dean Health Plan/Prevea360 Health Plan

Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ထၢးနှာ်လိၤဖဲအံၤ: ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်နှဉ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၢ်လၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိကွၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ် ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၢ် လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

Amharic/ አማርኛ:- ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።

Companion Life

Defined Contribution Plan
Proposed Group Insurance Benefit Summary
Prepared for: Otter Express Powers Board

Group Term Life Insurance

	Basic Life
Life Insurance Amount: Employer's Choice of	**$25,000**
Accidental Death and Dismemberment (AD&D) Insurance Amount	100% of life insurance amount
Spouse Life Insurance Amount	$5,000
Child Life Insurance Amount	
Age 14 days – 5 months	$100
Age 6 months – 26 years	$5,000
Benefits reduce by:	35% at age 65
	50% at age 70
	75% at age 75
Monthly Employee Rate per $1,000 (AD&D included)	$0.25

Voluntary Group Term Life Insurance

	Voluntary Life
Life Insurance Amount	**$10,000, or increments of $5,000 up to $100,000 maximum**
Accidental Death and Dismemberment (AD&D) Insurance Amount	100% of life insurance amount
Spouse Life Insurance Amount	$5,000, or increments of $5,000 up to $25,000 not to exceed 50% of Employee Election
Child Life Insurance Amount	$10,000
Age 14 days – 5 months	10% of the selected benefit
Age 6 months and over	$2,500
Benefits reduce by:	35% at age 65
	50% at age 70
	75% at age 75
	80% at age 80
Monthly Rate Table	Located in the following benefit pages

Companion Life

Group Dental Insurance

	Option 2
Allowance	90th Percentile
Deductible	$100 Lifetime
Type I	100%
Waiting period	None
Type II	80%
Waiting period	None
Type III	50%
Waiting period	None
Calendar Year Maximum	$1500
Orthodontia	50%
Ortho Lifetime Maximum	$1000
Ortho Waiting period	None
Preventative Waiver	Included
Increasing Maximum	N/A
Monthly Rates	**With Ortho**
Employee	$24.11
Employee + Spouse	$47.59
Employee + Child(ren)	$64.36
Employee + Family	$87.85

Group EyeMed Vision Insurance

EyeMed Vision Care	**EyeMed Access Network**
In-Network Benefits:	
Exam Co-Pay	$10
Exam Frequency	12 months
Lens Co-Pay	$10
Lens Frequency	12 months
Frames Co-Pay	$0
Frames Allowance	$130
Frames Frequency	24 months
Contact Lens Co-Pay (conventional)*	$0
Contact Lens Allowance*	$120
Contact Lens Frequency	12 months
Monthly Rates	
Employee	$7.63
Employee + Spouse	$15.26
Employee + Child(ren)	$17.75
Employee + Family	$28.36
***Contact lenses are in lieu of Eyeglass lenses**	

Accident Insurance Plan

Accident	
Proposed Plan:	$30,000
Wellness Benefit Option:	$75
Employee Accidental Death – all causes	$30,000
Employee Accidental Death – common carrier	$90,000
Monthly Rates	
Employee	$12.30
Employee + Spouse	$22.11
Employee + Child(ren)	$31.31
Employee + Family	$44.65

Companion Life Insurance Company

Defined Contribution Plan
Voluntary Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Proposal Prepared for: Otter Express Powers Board

PLAN INFORMATION

- Employees may elect a basic program of $10,000 or increments of $5,000 up to a maximum of $100,000.
- Spouses may elect increments of $5,000 up to a maximum of $25,000. The spouse's Voluntary Life Insurance benefit cannot exceed 50% of the employee's Voluntary Life Insurance amount.
- The dependent Child Benefit will be the Employee's option of: $10,000.
- Guaranteed Issue: Available at initial enrollment only
  Employee – up to $100,000 to age 65
  Spouse – up to $25,000 to age 65. Not to exceed 50% of the employee's coverage.
  Children – up to $10,000
  Age 0 - 5 months: 10% of the selected benefit
  6 months – 26 years: Full benefit
- Employees or spouses age 65 or older must submit Evidence of Insurability. Coverage is then subject to the Companion Life Underwriting process.
- Benefit amounts will reduce by 35% of the original amount at age 65, 50% at age 70, 75% at age 75, 80% at age 80. Benefits terminate at retirement. The spouse's benefit amount will reduce in accordance with the spouse's age.

Grandfathering of Voluntary Group Term Life benefits is available for approved enrollees.

MONTHLY RATES

AD&D Insurance Coverage is included in the rates shown. AD&D Insurance Coverage is not available for children.

Age	Rates per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
15-29	$0.12	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
30-34	$0.13	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00
35-39	$0.15	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00
40-44	$0.20	$2.00	$4.00	$6.00	$8.00	$10.00	$12.00	$14.00	$16.00	$18.00	$20.00
45-49	$0.32	$3.20	$6.40	$9.60	$12.80	$16.00	$19.20	$22.40	$25.60	$28.80	$32.00
50-54	$0.56	$5.60	$11.20	$16.80	$22.40	$28.00	$33.60	$39.20	$44.80	$50.40	$56.00
55-59	$0.82	$8.20	$16.40	$24.60	$32.80	$41.00	$49.20	$57.40	$65.60	$73.80	$82.00
60-64	$1.55	$15.50	$31.00	$46.50	$62.00	$77.50	$93.00	$108.50	$124.00	$139.50	$155.00
65-69	$2.42	$24.20	$48.40	$72.60	$96.80	$121.00	$145.20	$169.40	$193.60	$217.80	$242.00
70+	$4.44	$44.40	$88.80	$133.20	$177.60	$222.00	$266.40	$310.80	$355.20	$399.60	$444.00

CHILDREN'S COVERAGE AND MONTHLY RATES		
Benefit Amount:	$10,000	$1.60

Premium Rates for an insured will increase on the policyholder's next anniversary following the date the insured enters the next age bracket.

Defined Contribution Plan
Voluntary Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

VOLUNTARY GROUP TERM LIFE INSURANCE

Upon receiving proof that an Employee died while insured under the Policy, We will pay the amount of insurance in force at the time of his/her death to the beneficiary, in accordance with the Schedule of Benefits.

ACCELERATED BENEFIT - An eligible employee or spouse insured as of the policy effective date who becomes terminally ill while covered by Companion Life can immediately access up to 75% of the face value up to a maximum benefit of $100,000 of the Life Insurance Benefit without administrative or interest charges. Proceeds will be immediately available to the insured employee or spouse through the Insured Benefit Account.

CONVERSION - The amount of group term life insurance that may be converted is the Employee's group term life insurance reduced by the Accelerated Benefit amount paid.

REDUCTIONS - If a benefit reduces in accordance with a reduction provision, the total amount payable to the Insured will not be affected by the advanced payment.

FREQUENCY - Only one Accelerated Benefit payment will be made to the Insured.

ACCELERATED BENEFIT EXCLUSIONS – The Accelerated Benefit will not apply:

1. to any self-inflicted injuries or suicide attempts;
2. to any life insurance benefits for Dependent Children;
3. if an Insured person is Totally Disabled on his or her Effective Date of coverage under this Policy ;
4. to a group term life insurance benefit that has been assigned;
5. to a group term life insurance benefit payable to an irrevocable Beneficiary;
6. to a group term life insurance benefit with a face amount of less than $10,000; or
7. if the required group term life insurance premium is due and unpaid.

WAIVER OF PREMIUM - If an employee becomes totally disabled prior to age 60 while covered by this policy, Life Insurance coverage will be continued without payment of premium subject to any scheduled reductions and terminations. The employee may apply for this benefit after 12 months of total and continuous disability. Coverage continues for eligible employees whether or not the Master Policy remains in force, but terminates at the earlier of retirement or age 65.

CONVERSION - In the event of employment termination, an employee may convert Basic Group Life Insurance to an individual policy of permanent insurance. Conversion must be made within thirty-one (31) days following termination of employment.

PORTABILITY – If an insured employee's employment terminates for reasons other than sickness or injury, retirement, or plan termination, the employee may elect to continue employee and spouse coverage (not applicable to coverage for dependent children). The amount that may be continued is the amount in effect on the date Voluntary Group Term Life Insurance terminates, or a lesser amount in $25,000 increments ($12,500 increments for the spouse, not to exceed 50% of the employee amount). Spouse insurance may not be continued if the employee does not elect to continue employee insurance. Premiums are due no later than 31 days after the date the insurance would otherwise terminate, and are at the same rate applicable under the employer policy. This coverage will end if the employer's Master Policy terminates.

Defined Contribution Plan
Voluntary Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If the Employee or an insured Dependent suffer any of the following losses, We will pay the indicated percentage of the benefit amount. The loss must result from an Accidental Injury and independent of all other causes. The Accidental Injury must be caused by an accident that occurs while this benefit is in force as to the Insured. The loss must occur within 180 days of that accident. The benefit amount is shown in the Schedule of Benefits.

Accidental Loss of Life	100% of AD&D Benefit
Accidental Loss of Both Hands or Both Feet	100% of AD&D Benefit
Accidental Loss of Entire Sight of Both Eyes	100% of AD&D Benefit
Accidental Loss of One Hand and One Foot	100% of AD&D Benefit
Accidental Loss of One Hand and the Entire Sight of One Eye	100% of AD&D Benefit
Accidental Loss of One Foot and the Entire Sight of One Eye	100% of AD&D Benefit
Accidental Loss of One Hand or One Foot	50% of AD&D Benefit
Accidental Loss of Entire sight of One Eye	50% of AD&D Benefit
Accidental Loss of One Arm	50% of AD&D Benefit
Accidental Loss of One Leg	50% of AD&D Benefit

"Loss" as used above means:

1) arm, which means actual severance at or above the elbow;
2) leg, which means actual severance at or above the knee;
3) hand, which means: a. actual severance at or above the wrist, but below the elbow; or b. loss of a thumb and index finger on the same hand where the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb;
4) foot, which means actual severance at or above the ankle but below the knee; and
5) sight, which means: a. removal of the eye; or b. the permanent, uncorrectable loss of sight in at least one eye defined as either the corrected visual acuity of less than 20/200 or a visual field restriction of 20° or less which has persisted for 180 days from the date of loss. No benefit will be paid for loss of sight if, in the Physician's opinion, partial or total restoration of sight could occur naturally, or as a result of surgery or a device or implant.

If the Employee or an insured Dependent suffer more than one of the above losses as a result of the same accident, the benefit provided under this provision will be paid only for the greatest loss.

SEAT BELT BENEFIT

An additional 50% of the benefit amount will be paid if the Employee and/or the Employee's insured Dependents die or are dismembered as the result of a covered accident. The covered accident must occur while the Employee or one of the Employee's insured Dependents is driving an automobile and/or riding in an automobile; and all of the following apply:

1) the automobile must be equipped with seat belts;
2) the seat belt must have been in actual use and properly fastened at the time of the accident;
3) the position of the seat belt must be certified in the official report of the accident or by the investigating police officer;
4) the driver of the automobile must be properly licensed and must not have been driving while impaired, intoxicated or under the influence of drugs, unless prescribed by a licensed Physician, at the time of the accident;
5) "Automobile" means a four wheel passenger car, station wagon, jeep, pickup truck and van-type car; and
6) "Seat Belt" means the belts that form an occupant restraint system and includes infant and child restraint systems when properly used with a seat belt.

Defined Contribution Plan
Dental by Design

Proposal Prepared for: Otter Express Powers Board

IMPORTANT INFORMATION

FREEDOM OF CHOICE

With Companion Life Dental you're always free to see any dentist of your choosing.

You can, however, maximize your benefits by choosing an in-network provider. Dentists in our network have agreed to predetermined fees for services, which are discounted from standard charges.

Finding a provider is easy! You can search by practice, name, location, and/or specialty.

To find an in-network dentist, or find out if your current dentist is in-network, simply access our provider search at CompanionLife.com.

PREDETERMINATION OF BENEFITS

As a service to protect the insured, Companion Life will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps insureds better understand their coverage. The insured should have their provider submit the treatment plan to Companion Life for review and predetermination of benefits before the service begins.

An online Provider Portal is available to assist dental providers. Get started by visiting the Companion Life Website at www.companionlife.com.

COORDINATION OF BENEFITS

When a person is covered by two or more group plans, benefits available under these plans will be coordinated to avoid duplicate payments. One plan will have primary obligation for benefits while the other(s) will have secondary obligation.

ALLOWABLE CHARGE

ALLOWABLE CHARGE

Coinsurance percentage amounts are the same for both Participating and Non-Participating providers.

Companion Life Insurance Company

Defined Contribution Plan
Dental by Design – 90th Percentile

PLAN INFORMATION	
Deductible Per Individual Family Limit Waived for Type I service?	$100 Lifetime No Limit Yes
Type I Preventive Services Preventive Services Do Not count towards the annual maximum Benefit Waiting Period	100% Cleanings 2 per 12 months, Exams, Bitewing x-rays 1 per 12 months, Fluoride to age 19 None
Type II Basic Services Benefit Waiting Period	80% Full mouth X-rays, Space Maintainers to age 19, Sealants to age 19, Emergency Pain, Anterior Composite Fillings, Posterior Composite Fillings
Type III Major Services Benefit Waiting Period	50% Simple Extractions, Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Non-Surgical Periodontics, Surgical Periodontics, Anesthesia, Inlays, Onlays, Crowns, Crown Repairs, Bridges, Bridge Repairs, Dentures, Denture Repairs, Implants, Periodontal trays, TMJ*
Calendar Year Maximum	$1,500
Type IV Orthodontia Child(ren) Only Lifetime Maximum Deductible Benefit Waiting Period	50% Child(ren) Only $1,000 None None
Monthly Rates Employee Employee + Spouse Employee + Child(ren) Employee + Family	With Ortho $24.11 $47.59 $64.36 $87.85

*TMJ refers to Temporomandibular Joint Disease

Companion Life Insurance Company

Defined Contribution Plan
EyeMed Vision Insurance

Proposal Prepared for: Otter Express Powers Board

Vision by Design

EyeMed Access Provider Network*

This vision insurance offering utilizes Eyemed's Access provider network Companion Life, in association with EyeMed Vision Care, offers access to thousands of vision care providers including optometrists, ophthamologists, opticians, and many leading optical retailers such as Private Practitioners, LensCrafters, Target Optical, and most Pearle Vision locations.

- evening and weekend hours at many locations
- choice of thousands of fashionable, designer frames

***Not all providers or retailers available in all locations. To locate a provider in your area, go to eyemed.com and search by doctor's name, practice name, or zip code under the "Access" network option.**

MONTHLY RATES

Employee Only	$7.63
Employee + Spouse	$15.26
Employee + Child(ren)	$17.75
Employee + Family	$28.36

Companion Life Insurance Company

BENEFITS		Option 2 – Exam and Eyewear	
Vision Examination with Dilation as Necessary		In Network $10 Copay	Out of Network* $35 allowance
Contact Lens Fit and Follow-up (F&F) (Contacts lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)			
Standard**		$0 Copay	$40 allowance
Premium***		$0 Copay, 10% off retail price, then apply $55 allowance	$40 allowance
Frequency (Examination)		12 months****	12 months****
Frequency (Contact Lens F&F)		12 months****	12 months****
Standard Plastic Lenses		In Network	Out of Network*
Single		$10	$25
Bifocal		$10	$40
Trifocal		$10	$55
Other Add-Ons and Services		20% off retail price	N/A
Frequency		12 months****	12 months****
Lens Options		In Network	Out of Network*
UV Coating		$15	Discount available only at In Network providers and retailers
Tint (Solid and Gradient)		$15	
Standard Scratch Resistant Coating		$15	
Standard Polycarbonate		$40	
Standard Anti-Reflective Coating		$45	
Premium Anti-Reflective Coating		20% off retail price	
Standard Progressive (Add-on to Bifocal)		$75 Copay	$40
Premium Progressive (Add-on to Bifocal)		$75 Copay: 20% off retail price less $120 allowance	$40
Contact Lenses (Materials only)		In Network	Out of Network*
Conventional		$0 Copay $120 allowance 15% off balance over allowance	$96 allowance
Medically Necessary		$0 Copay	$200 allowance
Frequency		12 months****	12 months****
Frames Any available frame at provider location. Benefit is not available on those frames where the manufacturer prohibits a discount.		In Network $0 Copay $130 allowance 20% off balance over allowance	Out of Network* $72 allowance
Frequency		24 months*****	24 months*****

*When services are obtained from an out-of-network provider, a claim form must be filed with EyeMed for reimbursement. A claim form may be obtained at Eyemed.com.
**Standard Contact Lens Fitting-spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)
***Premium Contact Lens Fitting – all lens designs, materials and specialty fittings other than Standard (e.g., toric, multifocal, etc.)
****Once in a 12-month period defined by last date of service. Contact Lenses are in Lieu of EyeGlass Lenses.

*****Once in a 24-month period defined by last date of service.

In-Network Restrictions
Plan Option 2: Your plan design allows for the purchase of Contact Lenses and Frames, or Standard Plastic Lenses and Frames. It does not cover both Contact Lenses and Standard Plastic Lenses.

Defined Contribution Plan
Accident Insurance Plan

Proposal Prepared for Otter Express Powers Board

Accidental injuries can result in costly out-of-pocket expenses for employees and their families. Companion Life's Accident Insurance Plan can help alleviate some of the extra costs following injuries due to covered accidents. These benefit dollars may be used to help replace lost income, transportation, lodging, and other expenses. Benefits are paid directly to the employee in a lump sum, based on the Schedule of Benefits.

IMPORTANT INFORMATION	
Portability	• Employees who leave their current employer have the opportunity to continue their coverage for as long as the employer's group remains in force.
Benefits	• Apply to off the job only

PLAN & BENEFIT INFORMATION	
Proposed Plan Benefit	$30,000.00
Wellness Benefit Option	$75.00

MONTHLY RATES:	
Employee Only:	$12.30
Employee + Spouse:	$22.11
Employee + Child(ren):	$31.31
Employee + Family:	$44.65

PRODUCT PLAN PROVISIONS

The Benefits listed are payable if the service, treatment, or procedure is due to injuries incurred in a covered accident. Spouse / Child Benefits equal employee benefits as shown below except for Accidental Death and Dismemberment benefits.

Accidental Death and Dismemberment Benefits

- *Death or Loss must occur within 90 days*

	Benefit Plan		
Accidental Death	**Employee**	**Spouse**	**Child**
Accidental Death - all causes	$30,000	$15,000	$7,500
Accidental Death - common carrier	$90,000	$45,000	$22,500

Initial Accidental Loss or Dismemberment

Loss of both hands or both feet	$15,000	$7,500	$7,500
Loss of one hand and one foot	$15,000	$7,500	$7,500
Loss of one hand or foot	$7,500	$3,750	$3,750
Loss of two or more fingers, toes, or any combination	$3,000	$1,500	$1,500
Loss of one finger or toe	$1,500	$750	$750
Loss of sight of both eyes	$15,000	$7,500	$7,500
Loss of sight of one eye	$7,500	$3,750	$3,750
Loss of hearing of one ear	$7,500	$3,750	$3,750
Permanent Paralysis	$9,000	$4,500	$4,500

Catastrophic Accidental Loss or Dismemberment

- *Subject to 365 day Elimination Period*
- *Maximum of one benefit per lifetime per Insured Individuals*

Loss of both hands or both feet; or loss of one hand and one foot	$15,000	$7,500	$3,750
Loss of sight of both eyes	$15,000	$7,500	$3,750
Loss of hearing of both ears	$15,000	$7,500	$3,750
Permanent Paralysis	$15,000	$7,500	$3,750
Loss of the ability to speak	$15,000	$7,500	$3,750

Burns

- *Treatment must begin within 72 hours*

	Amount per Covered Accident
2nd degree 35+ square inches	$1,500
3rd degree at least 10-19 square inches	$1,500
3rd degree at least 20-34 square inches	$3,000
3rd degree 35+ square inches	$6,000
Skin Graft for 2nd or 3rd degree burns	50% of Burn benefit

Lacerations

- *Treatment must begin within 72 hours*

	Amount per Covered Accident
Laceration(s) not requiring sutures	$15
Laceration(s) repaired by stitches (Total of all lacerations is less than 2 inches)	$60
(Total of all lacerations is 2 – 6 inches)	$300
(Total of all lacerations is over 6 inches)	$600

Specific Covered Injuries / Dislocations & Fractures

- *Includes benefits per covered accident for: dislocations and fractures*
- *Injury must be diagnosed within 90 days of the Covered Accident*
- *Open reduction benefit is equal to 200% of the comparable closed reduction benefit*

Dislocation (Separated Joint)	Closed Reduction
Hip	$3,000
Knee or Shoulder	$1,500
Ankle or Foot (other than toes)	$1,500
Collarbone	$1,200
Lower Jaw	$600
Elbow or Wrist	$600
One Toe or Finger	$150
Incomplete dislocation or dislocation reduction without anesthesia	25% of the applicable amount for closed reduction of the joint listed above

Fractures	Closed Reduction
Depressed Skull Fracture	$3,000
Simple non-depressed Skull Fracture	$1,500
Hip	$3,000
Vertebrae (body of), Pelvis (excluding coccyx), or Sternum	$600
Leg (tibia or fibula)	$600
Nose, heel, or finger	$175
Upper Jaw (maxilla), upper arm, or face (except nose)	$300
Lower Jaw (mandibular)	$300
Shoulder Blade (scapula) or Forearm	$300
Vertebral Processes	$450
Wrist, elbow ankle, or kneecap	$300
Hand (except fingers)	$300
Foot (except toes/heel)	$300
Rib	$150
Coccyx	$150
Toe	$150
Chip Fracture	25% of the applicable amount for closed reduction of the bone listed above

Emergency, Hospital & Treatment Care Benefit

- *Includes benefits per covered accident for: Initial care, diagnostic and emergency services; hospital admission and confinement; emergency treatment*
- *Treatment / service time frame ranges from 48 hours to 1 year, or anytime if the Insured can prove a causal relationship between the Covered Accident and the loss.*
- *Maximum benefit period ranges from 15 days to 365 days*

	Amount per Covered Accident	Limitations Must Begin Within / Of a Covered Accident	Maximum Benefit Period
Emergency Room Treatment	$150	72 hours	2 per Calendar Year
Hospital Confinement	$300 per day	180 days	365 days
Hospital Intensive Care Confinement	$450 per day	30 days	15 days
Hospital Admission	$600	180 days	
Hospital Intensive Care Admission	$600	30 days	
Air Ambulance	$600	48 hours	
Ground Ambulance	$120	90 days	
Emergency Treatment in a Physician Office/Urgent Care Facility	$75 per visit	72 hours	2 per Calendar Year
Medical Imaging Benefit	$150	180 days	
Pain Management Epidural Anesthesia	$30	60 days	
Rehabilitation Unit Confinement	$60 per day		15 days per Confinement 30 days per Calendar Year
Physician Follow-up	$30 per visit		2 per Calendar Year
Therapy & Occupational, Physical, or Speech Therapy	$30 per accident	90 days	6 per Calendar Year
Chiropractic Treatment	$30 per visit	60 days and completed within: 180 days	3 per Calendar Year
Outpatient Surgery	$30	60 days	
Blood/Plasma/Platelets	$150	90 days	
Appliance	$120	90 days	
Prosthetic Device/Artificial Limb One More than one	 $250 $500	1 year	
Transportation (More than 100 miles round-trip from residence via plane, train, car, or bus)	$300 per round-trip		3 round-trips per Calendar Year
Lodging	$90 per night		30 nights per Calendar Year

Other Accidents & Benefits

- *Includes benefits per covered accident for: Coma, Concussion, Eye, Knee & other Benefits*
- *Injury / service time frame ranges from 72 hours to 1 year*

	Amount per Covered Accident	Limitations Must Begin Within / Of a Covered Accident
Coma	$6,000	30 days 14 or more consecutive days
Concussion	$60	72 hours
Emergency Dental Work Crown Extraction	 $120 $30	 60 days
Eye Injury with Surgical Repair	$150	90 days
Knee Cartilage Surgery Torn with surgical repair Exploratory without repair	 $300 $180	 60 days 1 year
Open Abdominal and Thoracic Surgery	$1,200	72 hours
Hernia with Surgical Repair	$120	30 days
Exploratory without Repair	$240	60 days
Ruptured Disc with Surgical Repair	$300	60 days Surgery must be performed within: 1 year
Tendon/Ligament/Rotator Cuff One surgical repair Two or more with surgical repair Exploratory without repair	 $200 $300 $120	 60 days Surgery must be performed within: 180 days