

You are eligible to enroll in our group medical insurance plan. We offer three medical plan options –Bronze, Silver and Gold. We also offer a Dental and Vision plan. You can now enroll in Dental and Vision separately from the medical plan. Below is a brief highlight of the medical plans we offer. Please note that we have a reference-based pricing plan in place. This means that there is no underlying, pre-negotiated network affiliated with our plan. Instead, our vendor HealthComp, will review and reprice medical bills working directly with providers.

| Calendar Year Benefits | GOLD PLAN | SILVER PLAN | BRONZE PLAN |
|------------------------|---|--|---|
| Deductible | \$2,000 Single /\$5,000 Family | \$3,500 Single /\$7,000 Family | \$7,000 Single/ \$14,000 Family |
| Out of Pocket Maximum | \$8,150 Single/ \$16,300 Family | \$8,150 Single/ \$16,300 Family | \$8,150 Single/ \$16,300 Family |
| Hospitalization | 20% after Deductible | 30% after Deductible | 40% after Deductible |
| Office Visit | \$40 copay Primary Care \$80 copay Specialist | 30% after Deductible | \$40 copay for 2 visits— then 40% after Deductible |
| Annual Physicals | No copay | No copay | No copay |
| Prescription Drugs | \$20 Generic \$40 Brand \$100 Non Formulary | 30% after Deductible | 40% after Deductible |
| Rx Mail Order | 2 copays for a 90 day supply | 30% after Deductible for a 90 day supply | 40% after Deductible for a 90 day supply |
| Urgent Care | \$50 copay | 30% after Deductible | 40% after Deductible |
| Emergency Room | 20% after Deductible | 30% after Deductible | 40% after Deductible |
| Diagnostic Xray & Lab | 20% after Deductible | 30% after Deductible | 40% after Deductible |

| DENTAL | |
|------------------------------|--------------------------------|
| Dental Calendar Year Maximum | \$1,500 per person |
| Calendar Year Deductible | \$50 Individual / \$150 Family |
| Preventive Care | 100% (no Deductible) |
| Basic Care | 80% after Deductible |
| Major Care | 50% after Deductible |
| Orthodontia | 50% after Deductible |
| Orthodontia LIFETIME max | \$1,500 |

| VISION | |
|----------------------------------|-----------------------|
| Eye Exam | \$50 every 12 months |
| Frames | \$100 every 24 months |
| Lenses | \$100 every 24 months |
| Contacts (in lieu of glasses) | \$100 every 24 months |

| Medical Plan Premium per Month [‡] | Gold | Silver | Bronze |
|---|------------|------------|------------|
| Employee | \$1,245.00 | \$1,000.00 | \$780* |
| Employee + Spouse | \$3,308.00 | \$2,627.00 | \$2,292.00 |
| Employee + Child | \$6,871.00 | \$5,564.00 | \$4,097.00 |
| Employee + Family | \$8,732.00 | \$7,825.00 | \$5,695.00 |
| *8 percent of gross wages capped at \$780/month. | | | |

| Dental & Vision Plan Premium per Month [‡] | |
|---|----------|
| Employee | \$96.00 |
| Employee + Spouse | \$193.00 |
| Employee + Child | \$232.00 |
| Employee + Family | \$329.00 |

Benefit / Enrollment Questions ?

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[‡]Premium amounts reflect the employee's responsibility for cost of coverage, should the employee elect to enroll in coverage for the current plan year or until employee termination or other Qualifying Life Event.