PPO PLAN DESIGNS
EMPLOYER CONTRIBUTION REQUIRED

	Retail Trade <500 Benchmark*	Option I	Option 2	Option 3
True Family or Embedded Deductible	DNA in Benchmark	Embedded	Embedded	Embedded
In-Network Deductible (Ind./Fam.) Out-of-Network Deductible (Ind./Fam.)	$1,500 / $3,750 $3,000 $6,000	$500 / $1,000 ● $1,000 / $2,000 ●	$1,000 / $2,000 ● $2,000/ $4,000 ●	$1,500 / $3,000 ● $3,000 / $6,000 ●
In-Network OOPM (Ind./Fam.) Out-of-Network OOPM (Ind./Fam.)	$4,750 / $10,000 $7,500 / $18,000	$4,000 / $8,000 ● $8,000 / $16,000 ●	$4,000 / $8,000 ● $8,000 / $16,000	$6,000 / $12,000 ● $12,000 / $24,000 ●
Coinsurance Amount (In-Network / Out-of-Network)	20% AD / 40% AD	20% AD / 40% AD ●	20% AD / 40% AD ●	30% AD / 40% AD
Preventive Services	100% In-Network	100% In-Network ●	100% In-Network ●	100% In-Network ●
Office Visit Copay (PCP / Specialist)	$28 / $50	$30 / $60 ●	$25 / $50 ●	$30 / $60 ●
ER Room / Urgent Care	$225 / DNA in Benchmark	$350 / $50 ●	$350 / $50 ●	$350 / $50 ●
Lab / X-ray	DNA in Benchmark	100%	100%	100%
Retail Prescription (30 day Supply)	$12 / $38 / $59	$10 / $35 / $60 ●	$10 / $35 / $60 ●	$10 / $35 / $60 ●
Mail Order Prescription (90 day Supply)	$22 / $75 / $116	$25 / $87.50 / $150 ●	$25 / $87.50 / $150 ●	$25 / $87.50 / $150 ●

AD = After Deductible
DNA = Data Not Available
* Mercer 2018 NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

● *Richer than benchmark*
● *Comparable to benchmark*
● *Less rich than benchmark*

HSA PLAN DESIGNS
EMPLOYER CONTRIBUTION REQUIRED

	Retail Trade <500 Benchmark*	Option 4	Option 5	Option 6	Option 7
True Family or Embedded Ded.	DNA in Benchmark	Embedded	Embedded	Embedded	Embedded
INN Deductible (Ind./Fam.) OON Deductible (Ind./Fam.)	$3,000 / $5,400 $6,175 / $12,000	$2,000 / $4,000 ● $5,000 / $10,000 ●	$3,000 / $6,000 ● $5,000 / $10,000 ●	$3,000 / $6,000 ● $5,000 / $10,000 ●	$6,000 / $12,000 ● $12,000 / $24,000 ●
INN OOPM (Ind./Fam.) OON OOPM (Ind./Fam.)	$5,000 / $10,000 $9,000 / $20,000	$4,000 / $8,000 ● $10,000 / $20,000 ●	$5,000 / $10,000 ● $10,000 / $20,000 ●	$5,000 / $10,000 ● $12,000 / $24,000 ●	$6,350 / $12,700 ● $12,700 / $25,400 ●
Coinsurance Amount (In-Network / Out-of-Network)	20% AD / 30% AD	0% AD / 30% AD ●	0% AD / 30% AD ●	20% AD / 40% AD ●	0% AD / 0% AD ●
Preventive Services	100% In-Network	100% In-Network ●	100% In-Network ●	100% In-Network ●	100% In-Network ●
Office Visit (PCP/Specialist)	20% AD / 30% AD	0% AD / 0% AD ●	0% AD / 0% AD ●	20% AD / 20% AD ●	0% AD / 0% AD ●
ER Room / Urgent Care	DNA in Benchmark Usually Coinsurance	0% AD / 0% AD	0% AD / 0% AD	20% AD / 20% AD	0% AD / 0% AD
Lab / X-ray	DNA in Benchmark Usually Coinsurance	0% AD / 0% AD	0% AD / 0% AD	20% AD / 20% AD	0% AD / 0% AD
Retail Prescription (30 day Supply)	DNA in Benchmark Usually Coinsurance	$10 AD / $35 AD / $60 AD	$10 AD / $35 AD / $60 AD	$10 AD / $35 AD / $60 AD	$10 AD / $35 AD / $60 AD
Mail Order Prescription (90 day Supply)	DNA in Benchmark Usually Coinsurance	$25 AD / $87.50 AD / $150 AD	$25 AD / $87.50 AD / $150 AD	$25 AD / $87.50 AD / $150 AD	$25 AD / $87.50 AD / $150 AD

AD = After Deductible
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● *Less rich than benchmark*

DENTAL PLAN DESIGNS
VOLUNTARY OR CONTRIBUTORY

	Retail Trade <500 Benchmark*	OPTION 1 Voluntary	OPTION 2 Voluntary	OPTION 3 Voluntary	OPTION 4 Contributory	OPTION 5 (MAC) Contributory
Deductible (Ind. / Fam.)	$50 / $125	$50 / $150 ●	$50 / $150 ●	$50 / $150 ●	$50 / $150 ●	$50 / $150 ●
Annual Maximum Benefit (Per Person)	$1,500	$1,000 ●	$1,000 ●	$1,000 ●	$2,000 ●	$1,000 ●
Preventive Care	100%	100% ●	100% ●	100% ●	100% ●	100% ●
Basic Care (Fillings, Extractions, Root Canals)	DNA in Benchmark Benefit is Standard	80% AD ●	80% AD ●	80% AD ●	80% AD ●	80% AD ●
Major Care (Bridges, Crowns, Dentures)	DNA in Benchmark Benefit is Standard	50% AD ●	50% AD ●	50% AD ●	50% AD ●	50% AD ●
Orthodontia	Not Covered	Not Covered ●	50% ●	Not Covered ●	50% ●	Not Covered ●
Maximum Lifetime Orthodontia Benefit When Covered	$1,500	Not Covered	$1,000 ●	Not Covered	$2,000 ●	Not Covered

AD = After Deductible
DNA = Data Not Available
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VISION PLAN DESIGNS
VOLUNTARY OR CONTRIBUTORY

	Option I Contributory	Option 2 Voluntary	Option 3 Voluntary	Option 4 Contributory
Routine Vision Exams (INN / OON)	$0 Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$0 Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$10 Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$10 Copay / Reimbursement up to $40 Frequency: 1 per 12 months
Single Vision Lenses (INN / OON)	$0 Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$0 Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$25Copay / Reimbursement up to $40 Frequency: 1 per 12 months	$25 Copay / Reimbursement up to $40 Frequency: 1 per 12 months
Frame Benefits (INN / OON)	$130 Allowance / Reimbursement up to $45 Frequency: 1 per 24 months	$130 Allowance / Reimbursement up to $45 Frequency: 1 per 24 months	$150 Allowance / Reimbursement up to $45 Frequency: 1 per 24 months	$150 Allowance / Reimbursement up to $45 Frequency: 1 per 24 months
In-Network Contact Lenses	Formulary: up to 4 boxes Non-Formulary $125 Allowance Necessary Contact Covered in Full After Copay	Formulary: up to 4 boxes Non-Formulary $125 Allowance Necessary Contact Covered in Full After Copay	Formulary: up to 4 boxes Non-Formulary $150 Allowance Necessary Contact Covered in Full After Copay	Formulary: up to 4 boxes Non-Formulary $150 Allowance Necessary Contact Covered in Full After Copay
Out-of-Network Contact Lenses	Elective Reimbursement of up to $125 Necessary Reimbursement of up to $210	Elective Reimbursement of up to $125 Necessary Reimbursement of up to $210	Elective Reimbursement of up to $150 Necessary Reimbursement of up to $210	Elective Reimbursement of up to $150 Necessary Reimbursement of up to $210

BASIC LIFE INSURANCE
EMPLOYER CONTRIBUTION REQUIRED

	Coverage
Flat Amount (Guaranteed Issue)	$25,000
Accelerated Benefit	Included
Waiver of Premium	Included
Age Reduction Schedule	Benefits Reduce to 65% at age 60, 50% @ age 70