20XX Guide to Employee Benefits

SAMPLE COMPANY INC.

Click to explore your benefit options.

Medical insurance is essential to your well-being and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Medical Plans

HOW A HEALTH PLAN WORKS

Preventive Care – like physical exams, flu shots and screenings – is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Annual deductible amount** – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Out-of-pocket maximums –** the most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copays –** A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance –** Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

MEDICAL PLANS COMPARISON

	PLAN 1		PLAN 2		PLAN 3	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE						
Individual	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Family	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
Individual	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Family	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
	YOU PAY		YOU PAY		YOU PAY	
COINSURANCE						
Preventive Care	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Primary Care Physician	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Specialist	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Urgent Care	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Emergency Room	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
PHARMACY						
RETAIL RX (UP TO 30-DAY SUPPLY)						
Tier 1	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Tier 2	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Tier 3	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
MAIL ORDER RX (UP TO 90-DAY SUPPLY)						
Tier 1	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Tier 2	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
Tier 3	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX

* After deductible

Taking care of your oral health is not a luxury, it is a necessity to long-term optimal health.

Dental Plans

With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative, and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

	DHMO PLAN (ONLY AVAILABLE IN CERTAIN STATES)	DPPO PLAN	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK†
CALENDAR YEAR† DEDUCTIBLE			
Individual	$XXX	$XXX	$XXX
Family	$XXX	$XXX	$XXX
CALENDAR YEAR† OUT-OF-POCKET MAXIMUM			
Per Individual	Unlimited	$XXX per individual (Basic and Major Services combined)	
	YOU PAY	YOU PAY	
SERVICES			
Office Visit	$XXX	$XXX	
PREVENTIVE CARE			
Exams, Cleanings, X-rays, Fluoride Treatments	$XXX	$XXX	XX%
BASIC SERVICES			
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	Various copays apply. See Schedule of Benefits.	XX%	XX%
MAJOR PROCEDURES			
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs	Various copays apply. See Schedule of Benefits.	XX%	XX%
ORTHODONTIA			
24-Month Treatment Fee—Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding			
Adults	$XXX	XX% up to a lifetime maximum benefit of $XXX per individual; deductible waived	
Children (up to 19th birthday)	$XXX		

Healthy eyes and clear vision are an important part of your overall health and quality of life.

Vision Plan

You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	VISION PLAN	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	YOU PAY	REIMBURSEMENT
COST		
Exam	$XXX	$XXX
Materials	$XXX	$XXX
COVERED SERVICES - LENSES		
Single Lenses	$XXX	$XXX
Bifocals	$XXX	$XXX
Trifocals	$XXX	$XXX
Frames	$XXX	$XXX
COVERED SERVICES - CONTACTS IN LIEU OF FRAMES/LENSES		
Contacts - Medically Necessary	$XXX	$XXX
Contacts - Elective	$XXX	$XXX
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 12 Months	Once every 12 Months