Effective January 1, 2019

COSTS FOR GROUP BENEFIT PLANS
ELIGIBLE REGULAR FULL-TIME & REGULAR PART-TIME (30-39 HOURS) TEAM MEMBERS

HEALTH CHOICE BENEFIT PLAN

HSA Silver Plans (offered by BCBS of IL, UnitedHealthcare and Aetna*)

	Weekly-Paid Team Members		Bi-Weekly-Paid Team Members	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
You Only	$8.81	$17.46	17.61	34.92
You and Spouse/Domestic Partner	$30.69	$39.35	$61.38	$78.69
You and Child(ren)	$30.69	$39.35	$61.38	$78.69
You and Family	$47.40	$56.05	$94.79	$112.10

HSA Gold Plans (offered by BCBS of IL, UnitedHealthcare and Aetna*)

	Weekly-Paid Team Members		Bi-Weekly-Paid Team Members	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
You Only	$16.53	$25.18	$33.05	$50.36
You and Spouse/Domestic Partner	$47.72	$56.38	$95.44	$112.75
You and Child(ren)	$47.72	$56.38	$95.44	$112.75
You and Family	$73.75	$82.41	$147.51	$164.81

POS Platinum Plans (includes all traditional POS plans offered by BCBS of IL, UnitedHealthcare, Aetna)

	Weekly-Paid Team Members		Bi-Weekly-Paid Team Members	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
You Only	$26.40	$35.05	$52.79	$70.10
You and Spouse/Domestic Partner	$74.98	$83.63	$149.95	$167.26
You and Child(ren)	$74.98	$83.63	$149.95	$167.26
You and Family	$115.79	$124.44	$231.58	$248.88

Note: Carrier availability is dependent upon the state in which you reside.

DENTAL BENEFIT PLAN

Aetna PPO	Weekly Paid Team Members*	Bi-Weekly Paid Team Members
You Only	$2.63	$5.26
You + Spouse/Domestic Partner	$6.34	$12.67
You + Child(ren)	$6.34	$12.67
You + Family	$10.18	$20.36

Aetna DMO	Weekly Paid Team Members*	Bi-Weekly Paid Team Members
You Only	$2.03	$4.06
You + Spouse/Domestic Partner	$4.72	$9.43
You + Child(ren)	$4.72	$9.43
You + Family	$7.61	$15.21

Note: The Aetna DMO will be offered in all states except Alabama, Alaska, Arkansas, Iowa, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota, Vermont and Wyoming, nor will it be offered in the Territories of Guam or Puerto Rico.

LONG TERM DISABILITY PLAN

The Plan provides for a monthly benefit amount equal to the lesser of:

- 60% of your pre-disability earnings, not reduced by deductible sources of income

Age	Rate per $100 of Coverage		Age	Rate per $100 of Coverage	
	Bi-Weekly	Weekly*		Bi-Weekly	Weekly*
Less than 25	$0.078	$0.039	45 – 49	$0.360	$0.180
25 – 29	$0.078	$0.039	50 – 54	$0.503	$0.252
30 – 34	$0.098	$0.049	55 – 59	$0.599	$0.300
35 – 39	$0.152	$0.076	60 – 64	$0.533	$0.267
40 – 44	$0.258	$0.129	65+	$0.386	$0.193

The cost varies by the above age-banded bi-weekly rates per $100 of coverage.

Use the following formula to get an estimate of your cost for LTD:

Bi-Weekly (ADM) = Insurance base **times** .05 (round to nearest dollar) **times** above age banded rate **divided by** 100

GROUP OPTIONAL TERM LIFE PLAN (1, 2, 3, 4, 5, 6, 7, or 8 times January 1 annualized earnings)

Age	Rate per $1,000 of Coverage Rate/1000		Age	Rate per $1,000 of Coverage Rate/1000	
	Bi-Weekly	Weekly*		Bi-Weekly	Weekly*
Less than 25	$ .014	$ .007	45 – 49	$ .042	$ .021
25 – 29	$ .017	$ .009	50 – 54	$ .062	$ .031
30 – 34	$ .021	$ .010	55 – 59	$ .114	$ .057
35 – 39	$ .024	$ .012	60 – 64	$ .180	$ .090
40 – 44	$ .028	$ .014	65 – 69	$ .277	$ .138
			70+	$ .554	$ .277

Formula: Annualized Earnings **times** 1,2,3,4,5,6,7,8 round up to nearest thousand **times** amount for age **divided by** 1000

DEPENDENT SPOUSE TERM LIFE PLAN

Age	Rate per $1,000 of Coverage Rate/1000		Age	Rate per $1,000 of Coverage Rate/1000	
	Bi-Weekly	Weekly*		Bi-Weekly	Weekly*
Less than 25	$0.023	$0.012	45 – 49	$0.069	$0.035
25 – 29	$0.028	$0.014	50 – 54	$0.106	$0.053
30 – 34	$0.037	$0.018	55 – 59	$0.198	$0.099
35 – 39	$0.042	$0.021	60 – 64	$0.305	$0.152
40 – 44	$0.046	$0.023	65 – 69	$0.586	$0.293
			70+	$0.951	$0.475

Spouse/Domestic Partner — $10,000 to $100,000 in increments of $10,000
Formula: Insurance base **times** amount for age of Spouse/Domestic Partner **divided by** 1000 based on above table.

DEPENDENT CHILD TERM LIFE PLAN

$ 5,000 ($.212 bi-weekly or $.106 a week* per $1,000 of coverage); or
$10,000 ($.425 bi-weekly or $.212 a week* per $1,000 of coverage); or
$20,000 ($.849 bi-weekly or $.425 a week* per $1,000 of coverage).

VISION BENEFIT PLAN

EyeMed		
Standard Plan	**Bi-Weekly**	**Weekly***
You Only	$ 3.37	$1.68
You + One	$6.40	$3.20
You + Two or More	$9.40	$4.70
Deluxe Plan	**Bi-Weekly**	**Weekly***
You Only	$5.14	$2.57
You + One	$9.76	$4.88
You + Two or More	$14.34	$7.17

***If you are a regular hourly team member who works in either New York or Rhode Island, your rates will be weekly.**