

Effective January 1, 2019

**COSTS FOR HEALTH CHOICE BENEFIT PLAN  
ELIGIBLE REGULAR PART-TIME TEAM MEMBERS**

**HEALTH CHOICE BENEFIT PLAN**

<b>HSA Silver Plans (offered by BCBS of IL, UnitedHealthcare and Aetna*)</b>				
	<b>Weekly-Paid Team Members</b>		<b>Bi-Weekly-Paid Team Members</b>	
	<b>Non-Tobacco User</b>	<b>Tobacco User</b>	<b>Non-Tobacco User</b>	<b>Tobacco User</b>
<b>You Only</b>	<b>\$47.38</b>	<b>\$56.04</b>	<b>\$94.77</b>	<b>\$112.07</b>
<b>You and Spouse/Domestic Partner</b>	<b>\$104.30</b>	<b>\$112.96</b>	<b>\$208.61</b>	<b>\$225.92</b>
<b>You and Child(ren)</b>	<b>\$104.30</b>	<b>\$112.96</b>	<b>\$208.61</b>	<b>\$225.92</b>
<b>You and Family</b>	<b>\$161.18</b>	<b>\$169.84</b>	<b>\$322.36</b>	<b>\$339.67</b>

<b>HSA Gold Plans (offered by BCBS of IL, UnitedHealthcare and Aetna*)</b>				
	<b>Weekly-Paid Team Members</b>		<b>Bi-Weekly-Paid Team Members</b>	
	<b>Non-Tobacco User</b>	<b>Tobacco User</b>	<b>Non-Tobacco User</b>	<b>Tobacco User</b>
<b>You Only</b>	<b>\$56.34</b>	<b>\$65.00</b>	<b>\$112.69</b>	<b>\$130.00</b>
<b>You and Spouse/Domestic Partner</b>	<b>\$123.95</b>	<b>\$132.60</b>	<b>\$247.90</b>	<b>\$265.20</b>
<b>You and Child(ren)</b>	<b>\$123.95</b>	<b>\$132.60</b>	<b>\$247.90</b>	<b>\$265.20</b>
<b>You and Family</b>	<b>\$191.55</b>	<b>\$200.21</b>	<b>\$383.10</b>	<b>\$400.41</b>

<b>POS Platinum Plans (includes all traditional POS plans offered by BCBS of IL, UnitedHealthcare, Aetna or Options PPO)</b>				
	<b>Weekly-Paid Team Members</b>		<b>Bi-Weekly-Paid Team Members</b>	
	<b>Non-Tobacco User</b>	<b>Tobacco User</b>	<b>Non-Tobacco User</b>	<b>Tobacco User</b>
<b>You Only</b>	<b>\$65.08</b>	<b>\$73.74</b>	<b>\$130.17</b>	<b>\$147.47</b>
<b>You and Spouse/Domestic Partner</b>	<b>\$143.18</b>	<b>\$151.83</b>	<b>\$286.35</b>	<b>\$303.66</b>
<b>You and Child(ren)</b>	<b>\$143.18</b>	<b>\$151.83</b>	<b>\$286.35</b>	<b>\$303.66</b>
<b>You and Family</b>	<b>\$221.27</b>	<b>\$229.92</b>	<b>\$442.54</b>	<b>\$459.85</b>

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

## VISION BENEFIT PLAN

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

### **Part Time Eligibility Rules:**

- A regular part-time (RPT) team member must be scheduled to work 20 or more hours per week and less than 30 hours to enroll and,
- RPT new hires have a 90-day waiting period before coverage begins.
- RPT team members that work an average of 30-39 hours per week will be eligible for full-time health & welfare benefits and rates.
- Eligibility will be determined by the hours worked in the prior full calendar year.

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