Medical Benefits

Premier Cooperative, Inc. is pleased to provide eligible employees and dependents with the choice of two medical plans through Health Alliance Medical Plans. For your reference, we have highlighted some of the most frequently used benefits below but encourage you to review the Summary of Benefits & Coverage or Summary Plan Description for complete details on exclusion, limitations, and pre-authorization requirements.

Health Alliance Medical Plans GOLD POS 1000 Rx 231	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductible		
▪ Individual	$1,000	$3,000
▪ Family	$2,000	$6,000
Benefit Coinsurance (carrier pays)		
	80%	60%
Out-of-Pocket Maximum (includes copays & deductible)		
▪ Individual	$4,000	$12,000
▪ Family	$8,000	$24,000
Physician Office Visits		
▪ Primary Care (PCP)	$25 copay per visit	40% coinsurance after deductible
▪ Specialists Visits (SPC)	$40 copay per visit	40% coinsurance after deductible
Preventive Care & Wellness Services		
	100%	40% coinsurance after deductible
Laboratory & X-ray Services		
▪ Diagnostic X-Ray & Lab	20% coinsurance after deductible	40% coinsurance after deductible
▪ Complex Radiology	20% coinsurance after deductible	40% coinsurance after deductible
Hospital Services		
▪ Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
▪ Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room		
	$250 copay; waived if admitted	
Urgent Care Services		
	$50 copay per visit	40% coinsurance after deductible
Prescription Drugs (Retail up to 30-day supply)		
▪ Generic – Tier 1 & 2	$0 or $10 copay	50% coinsurance
▪ Brand (Formulary) – Tier 3	$40 copay	50% coinsurance
▪ Brand (Non-Formulary) – Tier 4	$80 copay	50% coinsurance
▪ Preferred Specialty – Tier 5 & 6	30% / 50% coinsurance	50% coinsurance
Prescription Drugs (Mail Order up to 90-day supply)		
▪ Generic	$0 or $27.50 copay	N/A
▪ Brand (Formulary)	$110 copay	N/A
▪ Brand (Non-Formulary)	$220 copay	N/A
▪ Preferred Specialty	N/A	N/A

Bi-Weekly Employee Contributions for Gold Plan

Effective: 01/01/2025			
Employee **$41.04**	Employee & Spouse **$178.42**	Employee & Child(ren) **$148.98**	Family (Employee, Spouse & Child(ren)): **$303.45**

Health Alliance Medical Plans SILVER POS 2500 Rx 231	In-Network Benefits	Out-of-Network Benefits
Calendar Year Deductible		
▪ Individual	$2,500	$7,500
▪ Family	$5,000	$15,000
Benefit Coinsurance (carrier pays)		
	80%	60%
Out-of-Pocket Maximum (includes copays & deductible)		
▪ Individual	$4,500	$13,500
▪ Family	$9,000	$27,000
Physician Office Visits		
▪ Primary Care (PCP)	$25 copay per visit	40% coinsurance after deductible
▪ Specialists Visits (SPC)	$40 copay per visit	40% coinsurance after deductible
Preventive Care & Wellness Services		
	100%	40% coinsurance after deductible
Laboratory & X-ray Services		
▪ Diagnostic X-Ray & Lab	20% coinsurance after deductible	40% coinsurance after deductible
▪ Complex Radiology	20% coinsurance after deductible	40% coinsurance after deductible
Hospital Services		
▪ Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
▪ Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room		
	$250 copay; waived if admitted	
Urgent Care Services		
	$50 copay per visit	40% coinsurance after deductible
Prescription Drugs (Retail up to 30-day supply)		
▪ Generic – Tier 1 & 2	$0 or $10 copay	50% coinsurance
▪ Brand (Formulary) – Tier 3	$40 copay	50% coinsurance
▪ Brand (Non-Formulary) – Tier 4	$80 copay	50% coinsurance
▪ Preferred Specialty – Tier 5 & 6	30% / 50% coinsurance	50% coinsurance
Prescription Drugs (Mail Order up to 90-day supply)		
▪ Generic	$0 or $27.50 copay	N/A
▪ Brand (Formulary)	$110 copay	N/A
▪ Brand (Non-Formulary)	$220 copay	N/A
▪ Preferred Specialty	N/A	N/A

Bi-Weekly Employee Contributions for Silver Plan

Effective: 01/01/2025			
Employee **$15.27**	Employee & Spouse **$148.38**	Employee & Child(ren) **$119.89**	Family: Employee, Spouse & Child(ren) **$261.45**

Flexible Spending Account (FSA)

You have an option to participate in the Flexible Spending Account (FSA) administered by Chard Snyder. This plan allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars for medical, dental, vision, and over-the-counter health care. All insurance copays and deductibles, qualified prescriptions, insulin, and medical devices are covered. FSAs can also be used to pay for first aid items, personal care items, and over-the-counter medicines and vitamins. Check the FSA Store Eligibility List for a more comprehensive list: https://fsastore.com/fsa-eligibility-list

The plan is comprised of a healthcare spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

If you elect the FSA account, your election will be effective January 1, 2025, through December 31, 2025.

How An FSA Works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service **OR** submit the appropriate paperwork to be reimbursed by the plan.

Important Rules to Keep In Mind

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.
- You cannot use your FSA money to reimburse/pay for expenses that the employer-funded portion of the HRA reimbursed.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

Maximum Annual Election	
Health Care FSA	$3,300
Dependent Care FSA	$5,000

Dental Benefits

Dental benefits provide you and your family with comprehensive coverage to keep your smile shining bright! This benefit is a shared cost with the company. The chart below provides you with a summary of the key benefits of the dental insurance available from Mutual of Omaha Insurance Company. For a complete list of all your dental insurance benefits and restrictions, please refer to your booklet or contact your plan administrator.

Voluntary Pre-Authorization

In the event you need to have dental work estimated to cost $300 or more, we recommend you have your dentist submit the charges to the carrier for pre-authorization. They will then review the intended treatment plan and let your dentist know how much of the bill they will cover. We recommend this to avoid any billing issues.

Mutual of Omaha Insurance Company	In-Network Benefits
Calendar Year Deductible	
▪ Waived for Preventive Care?	Yes
▪ Individual	$50
▪ Family	$150
Benefit Maximum (Plan year)	$1,000
Preventive Care Services	100%
Basic Services	80%
Major Services	50%
Orthodontia (Adults and eligible dependents)	$1,000
Non-Network Benefits*	*Preventive Care Services: 100%* *Basic Services: 80%* *Major Services: 50%* *Orthodontia: 50%*

***If you use a non-participating PPO provider, you will pay more out-of-pocket since those providers do not have negotiated rates with your dental carrier. You will also be responsible for any amount over reasonable and customary (R&C).*

Members who enroll more than 31 days after becoming initially eligible will be subject to an individual benefit waiting period, subject to policy guidelines. A complete list is included in your booklet.

Bi-Weekly Employee Contributions

Voluntary Dental Rates	Effective: 1/1/2025
Employee	$3.86
Employee & Spouse	$16.89
Employee & Child(ren)	$17.51
Family: Employee & Spouse & Child(ren)	$37.30

Vision Benefits

Premier Cooperative, Inc. has designed a vision plan that includes coverage for both an annual vision exam as well as vision hardware benefits. You should always use an in-network provider whenever possible to receive the highest benefit level.

Vision Service Plan – VSP	In-Network Benefits
Vision Exams	
▪ Benefit	$10 copay
▪ Frequency	12 months
Vision Materials	
▪ Materials Copay	$25 copay
▪ Lenses	Benefits vary by type of lens. Covered every 12 months
▪ Contacts Covered in place of frames. Medically necessary contacts may be covered at a higher benefit level.	Elective contacts covered $130 Allowance for contacts; copay does not apply. Contact lens exam (fitting and evaluation) up to $130 copay every 12 months
▪ Frames	Covered at a $130 Allowance for a wide selection of $150 allowance for featured frame brands every 12 months

Bi-Weekly Employee Contributions

Voluntary Vision Rates	Effective: 1/1/2025
Employee	$4.01
Employee & Spouse	$6.41
Employee & Child(ren)	$6.54
Family: Employee & Spouse & Child(ren)	$10.55

Life & Accidental Death and Dismemberment

Premier Cooperative, Inc. provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Mutual of Omaha Insurance Company	
All eligible employees	
Life Benefit	$30,000
AD&D Benefit	Equal to the life insurance benefit or as indicated in the contract based on the type of loss

The above benefits will begin to decrease at age 65.

Beneficiary

Remember to keep your beneficiary updated, which can be done anytime throughout the year. If you are married and living in a community property state, your insurance carrier may require that you designate your spouse (or in some cases a registered domestic partner) for at least 50% of the benefit unless you have a waiver notice on file from your spouse. Consult your legal or tax advisor for further guidance on this issue.

Short-Term Disability Insurance

Premier Cooperative, Inc. is pleased to provide employees with short-term disability benefits through Mutual of Omaha Insurance Company.
For an eligible disability, these benefits will provide short-term income protection once the applicable waiting period is met.
A brief description is below, and additional information can be found in your certificate of coverage.

Mutual of Omaha Insurance Company	Short Term Disability (STD) G000B7HS All Eligible Employees
Benefit Amount	70%
Benefit Maximum	$1,500
Waiting Period	Accident: 7 days / Sickness: 7 days
Benefit Period	Up to 25 weeks