

Indiana Employers Trust

Anthem	PPO 18 Rx E5	PPO 21 Rx E5	PPO 21 Rx E6	PPO 24 Rx E6	PPO 25 Rx E6
In Network Benefits					
Individual Deductible	\$2,000	\$3,000	\$3,000	\$4,000	\$5,000
Family Deductible	\$6,000	\$9,000	\$9,000	\$12,000	\$10,000
Coinsurance	70%	70%	70%	80%	80%
Individual Max Out of Pocket	\$5,000	\$6,000	\$6,000	\$6,350	\$6,350
Family Max Out of Pocket	\$10,000	\$12,000	\$12,000	\$12,700	\$12,700
Office Visit Copay	\$25	\$30	\$30	\$30	\$35
Specialist Copay	\$25	\$30	\$30	\$30	\$35
Urgent Care Copay	\$75	\$75	\$75	\$75	\$75
Emergency Room Copay	\$250/30%	\$250/30%	\$250/30%	\$250/20%	\$250/20%
Non Network Benefits					
Individual Deductible	\$4,000	\$6,000	\$6,000	\$8,000	\$10,000
Family Deductible	\$12,000	\$18,000	\$18,000	\$24,000	\$20,000
Coinsurance	50%	50%	50%	60%	60%
Individual Max Out of Pocket	\$10,000	\$12,000	\$12,000	\$16,000	\$20,000
Family Max Out of Pocket	\$20,000	\$24,000	\$24,000	\$32,000	\$40,000
Prescription Drug Benefits					
Retail			\$250 Rx Deductible	\$250 Rx Deductible	\$250 Rx Deductible
Tier 1	\$15	\$15	\$15	\$15	\$15
Tier 2	\$45	\$45	\$45	\$45	\$45
Tier 3	\$75	\$75	\$75	\$75	\$75
Tier 4	25% to \$250	25% to \$250	25% to \$250	25% to \$250	25% to \$250
Mail					
Tier 1	\$15	\$15	\$15	\$15	\$15
Tier 2	\$115	\$115	\$115	\$115	\$115
Tier 3	\$225	\$225	\$225	\$225	\$225
Tier 4	25% to \$250	25% to \$250	25% to \$250	25% to \$250	25% to \$250
Network	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access

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In Network Benefits					
Individual Deductible	\$2,650	\$2,800	\$4,000	\$5,000	\$5,000
Family Deductible	\$5,300	\$5,600	\$8,000	\$10,000	\$10,000
Coinsurance	100%	100%	100%	100%	100%
Individual Max Out of Pocket	\$3,450	\$3,650	\$5,000	\$6,450	\$6,650
Family Max Out of Pocket	\$6,850	\$7,300	\$10,000	\$12,900	\$13,300
Office Visit Copay	Deductible	Deductible	Deductible	Deductible	Deductible
Specialist Copay	Deductible	Deductible	Deductible	Deductible	Deductible
Urgent Care Copay	Deductible	Deductible	Deductible	Deductible	Deductible
Emergency Room Copay	Deductible	Deductible	Deductible	Deductible	Deductible
Non Network Benefits					
Individual Deductible	\$5,300	\$5,300	\$8,000	\$10,000	\$10,000
Family Deductible	\$10,600	\$10,600	\$16,000	\$20,000	\$20,000
Coinsurance	70%	70%	70%	70%	70%
Individual Max Out of Pocket	\$10,600	\$10,600	\$16,000	\$20,000	\$20,000
Family Max Out of Pocket	\$21,200	\$21,200	\$32,000	\$40,000	\$40,000
Prescription Drug Benefits					
Retail					
Tier 1	Ded, then \$10	Ded, then \$10	Ded, then \$10	Ded, then \$10	Ded, then \$10
Tier 2	Ded, then \$30	Ded, then \$30	Ded, then \$30	Ded, then \$30	Ded, then \$30
Tier 3	Ded, then \$60	Ded, then \$60	Ded, then \$60	Ded, then \$60	Ded, then \$60
Tier 4	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250
Mail					
Tier 1	Ded, then \$10	Ded, then \$10	Ded, then \$10	Ded, then \$10	Ded, then \$10
Tier 2	Ded, then \$30	Ded, then \$30	Ded, then \$30	Ded, then \$30	Ded, then \$30
Tier 3	Ded, then \$60	Ded, then \$60	Ded, then \$60	Ded, then \$60	Ded, then \$60
Tier 4	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250	Ded, then 25% to \$250
Network	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access

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<i>MetLife Dental</i>	<i>1000 no Ortho</i>	<i>1000 Ortho</i>	<i>1500 no Ortho</i>	<i>1500 Ortho</i>	<i>2000 no Ortho</i>	<i>2000 Ortho</i>
Plan Eligibility	FT EE's/30+ Hrs	FT EE's/30+ Hrs	FT EE's/30+ Hrs	FT EE's/30+ Hrs	FT EE's/30+ Hrs	FT EE's/30+ Hrs
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO
Deductible - Individual	\$50 / \$50	\$50 / \$50	\$50 / \$50	\$50 / \$50	\$50 / \$50	\$50 / \$50
Deductible - Family	\$150 / \$150	\$150 / \$150	\$150 / \$150	\$150 / \$150	\$150 / \$150	\$150 / \$150
Deductible - Waived for Prev	Yes	Yes	Yes	Yes	Yes	Yes
Calendar Year Maximum	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000
Prev Applied to Cal Max	Yes	Yes	Yes	Yes	Yes	Yes
Orthodontia Lifetime Max	N/A	\$1,000	N/A	\$1,500	N/A	\$2,000
Orthodontia - Children/Adult	N/A	Children Only	N/A	Children Only	N/A	Children Only
Preventive	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	100% / 100%
Basic	80% / 80%	80% / 80%	80% / 80%	80% / 80%	90% / 90%	90% / 90%
Major	50% / 50%	50% / 50%	50% / 50%	50% / 50%	60% / 60%	60% / 60%
Orthodontia	N/A	50% / 50%	N/A	50% / 50%	N/A	50% / 50%
Sealants	Preventive	Preventive	Preventive	Preventive	Preventive	Preventive
Endodontics	Major	Major	Basic	Basic	Basic	Basic
Periodontics	Major	Major	Basic	Basic	Basic	Basic
Oral Surgery / Anesthesia	Major	Major	Basic	Basic	Basic	Basic
Implants	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
TMJ	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OON Reimbursement	90th Percentile	90th Percentile	90th Percentile	90th Percentile	90th Percentile	90th Percentile
Maximum Rollover	No	No	No	No	No	No
Waiting Periods	None	None	None	None	None	None
Minimum Contribution	75%	75%	75%	75%	75%	75%
Provider Lookup	www.metlife.com	www.metlife.com	www.metlife.com	www.metlife.com	www.metlife.com	www.metlife.com
	ER Paid	ER Paid	ER Paid	ER Paid	ER Paid	ER Paid
Employee	\$24.49	\$24.49	\$29.78	\$29.78	\$34.97	\$34.97
Employee + Spouse	\$49.98	\$49.98	\$60.83	\$60.83	\$71.35	\$71.35
Employee + Child(ren)	\$58.52	\$65.36	\$71.21	\$80.46	\$83.57	\$92.83
Employee + Family	\$88.87	\$96.93	\$108.31	\$119.12	\$126.99	\$137.80
	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
Employee	\$27.41	\$27.41	\$33.36	\$33.36	\$39.17	\$39.17
Employee + Spouse	\$55.93	\$55.93	\$68.15	\$68.15	\$79.94	\$79.94
Employee + Child(ren)	\$62.87	\$69.23	\$75.51	\$85.28	\$88.58	\$98.34
Employee + Family	\$94.24	\$102.78	\$114.77	\$126.23	\$134.64	\$146.11

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MetLife Vision	Low Option	High Option
Plan Eligibility	FT EE's/30+ Hrs	FT EE's/30+ Hrs
Exam Frequency	1 Per 12 Months	1 Per 12 Months
Contact / Lens Frequency	1 Per 24 Months	1 Per 12 Months
Frames Frequency	1 Per 24 Months	1 Per 24 Months
<u>In-Network Copays</u>	<u>In-Network</u>	<u>In-Network</u>
Exam	\$20 Copay	\$10 Copay
Single Lenses	\$20 Copay	\$20 Copay
Bifocal Lenses	\$20 Copay	\$20 Copay
Trifocal Lenses	\$20 Copay	\$20 Copay
Frames	\$130 Allowance, 20% Discount	\$150 Allowance, 20% Discount
Contact Lenses	\$130 Allowance	\$150 Allowance
Frames Covered if Contacts Elected	No	No
Employer Minimum Contribution	75%	75%
Minimum Participation Requirement	65%	65%
Provider Lookup	www.metlife.com	www.metlife.com
	<i>ER Paid</i>	<i>ER Paid</i>
Employee	\$4.54	\$5.85
Employee + Spouse	\$7.94	\$10.23
Employee + Child(ren)	\$8.61	\$11.11
Employee + Family	\$13.15	\$16.96
	<i>Voluntary</i>	<i>Voluntary</i>
Employee	\$6.10	\$7.97
Employee + Spouse	\$10.68	\$13.94
Employee + Child(ren)	\$11.59	\$15.14
Employee + Family	\$17.69	\$23.10

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MetLife Life & AD&D and Voluntary Life

	ER Paid		Voluntary	
Plan Eligibility	FT EE's/30+ Hrs	Eligibility	FT EE's/30+ Hrs	
Benefit Amount	Flat \$15K, \$25k, \$50k or \$75k	Employee Benefit	\$25K Increments	
Maximum Benefit	\$75K	Employee Maximum	\$300,000	
Guaranteed Issue	\$75K	Employee Guarantee Issue	\$100,000	
Portability	No	Employee Reduction Schedule	None	
Conversion	Yes	Spouse Benefit	\$10,000 Increments	
Reduction Schedule	To 65% at 65, 50% at 70	Spouse Maximum	\$50,000 / 50% of EE	
Employer Contribution	100%	Spouse Guarantee Issue	\$20,000	
Participation Requirement	100%	Child Benefit	\$5,000	
		Child Maximum	\$5,000	
Life Rate per \$1000	\$0.200	Portability	Yes	
AD&D Rate per \$1000	\$0.025	Conversion	Yes	
			<u>Employee</u>	<u>Spouse</u>
		Age 00-19	\$0.060	\$0.060
		Age 20-24	\$0.060	\$0.060
		Age 25-29	\$0.060	\$0.060
		Age 30-34	\$0.080	\$0.060
		Age 35-39	\$0.100	\$0.080
		Age 40-44	\$0.120	\$0.100
		Age 45-49	\$0.190	\$0.120
		Age 50-54	\$0.320	\$0.190
		Age 55-59	\$0.550	\$0.320
		Age 60-64	\$0.760	\$0.550
		Age 65-69	\$1.340	\$0.760
		Age 70-74	\$2.760	\$1.340
		Age 75-79	\$2.760	\$1.340
		Age 80-00	\$2.760	\$1.340
		Child Life Rate	\$0.200	
		EE AD&D Rate	\$0.020	
		SP AD&D Rate	\$0.020	
		CH AD&D Rate	\$0.060	
		Rates are per \$1,000 of Coverage		