



Associated Employers
& AE Benefit Plans

Group Benefit Plan & Trust

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Presented To:

WYOMING CHAMBER PROGRAMS

June 1, 2025

Welcome to your 2025 Benefits! Associated Employers (AE) is a voluntary, non-profit employers' resource association that has been dedicated to assisting members with their human resource, safety and employee benefit needs since 1916. The Associated Employers Group Benefit Plan & Trust is a partially self-funded multiple employer welfare arrangement (MEWA) operating under Federal Department of Labor regulations governed by the Employee Retirement Income Security Act (ERISA). The Associated Employers Group Benefit Plan & Trust is administered by a Board made up of plan participants who voluntarily and without compensation contribute their time and talents to directing the operation of the Trust. The Trust currently covers over 7,300 employee lives. Employee Benefit Management Services (EBMS), based in Billings, Montana, has been the TPA for the AE Trust since 1980.

Requirements to Participate in the Trust.

- Participation in the Trust requires the employer to maintain an annual membership in Associated Employers.
- Employer must have a business location in Wyoming or Montana.
- Employer must cover at least one employee, who is not related to the owner(s) by bloodline or marriage.
- Employer will designate a minimum hour requirement for eligibility between 20-35 hours per week and all employees working the minimum hours required must be offered coverage once they have completed the waiting period.
- Employer contributing less than 100% of the cost of coverage for its employees are prohibited per Federal Law from using a formula which discriminates in favor of its highly compensated employees and owners. The contribution towards all eligible individuals must be the same.
- The Trust requires a minimum of 70% of eligible employees must enroll on the Plan.
- A minimum of \$5,000 in life coverage is required for each employer offering medical benefits.
- Completed and signed employee enrollment/waiver forms are required from each eligible employee.
- The Trust holds open enrollment in December for January 1st and in March for April 1st. Changes in enrollment can only be made outside of these dates if the individual has a qualifying event.

Summary of Benefits & Coverage (SBC).

The SBCs for the AEGBP&T plans can be used to compare differences between the health plans and are available for review at <http://sbc.aetrust.org>.

This benefit summary is for informational purposes only. All benefits and general provisions described herein are subject to the terms, limitations, and exclusions of the Summary Plan Descriptions for the Associated Employers Group Benefit Plan & Trust.

TRADITIONAL MEDICAL PLAN OPTION 1

Benefit Period	Calendar Year (January 1 – December 31)	
Deductible (An individual covered person cannot receive credit toward the family deductible for more than the individual annual deductible amount.)	Individual - \$1,500	Family - \$3,000
Co-Insurance & Out-of-Pocket	70/30	\$3,500 Individual/\$7,000 Family
Maximum Out-of-Pocket	Individual - \$5,000	Family - \$10,000
Out-of-Network	<ul style="list-style-type: none"> • Subject to separate deductible and co-insurance amount, equal to 2 times the PPO deductible and co-insurance amount • Co-insurance level will also be reduced to 55/45 	
BENEFIT HIGHLIGHTS		
Medical benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)		
Deductible and co-insurance apply to all services listed below, unless noted otherwise. Benefits and general provisions described herein are only a summary and are subject to the terms of the Summary Plan Document.		
Primary Care Co-Pay	\$35 per office visit; Provider must be in network <i>Services provided in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Urgent Care	\$75 co-pay per office visit; Provider must be in network <i>Facility and other charges for services in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Preventive Services (Subject to frequency limitations determined by the U.S. Preventive Services Task Force and Health Resources and Services Administration)	Paid at 100%, deductible waived Services include: <ul style="list-style-type: none"> • Well child care • Routine physical exams, office visits, x-ray and lab services • Immunizations/vaccinations • Prostate screening and PSA • Diabetes screening • Women’s Preventive Services, including <ul style="list-style-type: none"> ○ office visits and well-women visits ○ mammogram (age 40 and over) ○ gynecological exam ○ Pap smear ○ counseling for sexually transmitted infections ○ human papillomavirus (HPV) testing ○ counseling/screening for HIV, domestic violence, contraceptive methods ○ sterilization procedures ○ screening for gestational diabetes in pregnant women ○ breastfeeding support, supplies, and counseling in conjunction with each birth • Screening colonoscopy or flexible sigmoidoscopy with no medical diagnosis; subject to age/frequency limitations set by USPSTF • Health risk screening, which includes CMP, LP, CBC, TSH, Vit D and blood pressure screening; one per benefit period 	
Professional Provider Services	Deductible and co-insurance apply, unless visit falls under primary care co-pay	
Maternity Benefits	Deductible and co-insurance apply, except for routine prenatal office visits at participating provider (see below) Routine prenatal office visits with participating provider are covered as follows: <ul style="list-style-type: none"> • 40% of covered expenses of global maternity fee paid at 100% deductible waived OR • 100% of routine prenatal office visits if billed separately 	
Emergency Room	Deductible and co-insurance apply	
Alternative Care	Deductible and co-insurance apply \$500 combined yearly benefit for medically necessary chiropractic/spinal manipulation, massage therapy, and acupuncture	
Mental Illness	Processed under medical benefits	

TRADITIONAL MEDICAL PLAN OPTION 1 – Continued

Chemical Dependency	Processed under medical benefits
Home Health Care	Up to 40 visits per benefit period
Habilitative/Rehabilitative Therapy	Includes physical, occupational, and speech therapy Requires order by physician
<p>Prescription Drugs</p> <p>(Only available through preferred providers)</p> <p>See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com</p>	<p>Retail pharmacy (for a 30-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Name Formulary - \$45 copay, no deductible applies • Brand Name Non-Formulary – 35% coinsurance, no deductible applies <p>Retail/Mail Order pharmacy (for a 90-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Name Formulary - \$90 copay, no deductible applies • Brand Name Non-Formulary – 35% coinsurance, no deductible applies <p>Specialty Medications</p> <ul style="list-style-type: none"> • Generic Specialty Drugs - \$15 copay, no deductible applies • Brand Specialty Drugs - \$200 copay, no deductible applies • Examples include high-cost injectables, infused, oral or inhaled medications prescribed for chronic disease conditions • Covered under Lumicera Health Services Specialty Pharmacy • For information call 1-855-847-3553

TRADITIONAL MEDICAL PLAN OPTION 2

Benefit Period	Calendar Year (January 1 – December 31)	
Deductible (An individual covered person cannot receive credit toward the family deductible for more than the individual annual deductible amount.)	Individual - \$3,000	Family - \$6,000
Co-Insurance & Out-of-Pocket	50/50	\$5,000 Individual/\$10,000 Family
Maximum Out-of-Pocket	Individual - \$8,000	Family - \$16,000
Out-of-Network	<ul style="list-style-type: none"> • Subject to separate deductible and co-insurance amount, equal to 2 times the PPO deductible and co-insurance amount • Co-insurance level will also be reduced to 40/60 	
BENEFIT HIGHLIGHTS		
Medical benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)		
Deductible and co-insurance apply to all services listed below, unless noted otherwise. Benefits and general provisions described herein are only a summary and are subject to the terms of the Summary Plan Document.		
Primary Care Co-Pay	\$35 per office visit; Provider must be in network <i>Services provided in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Urgent Care	\$75 co-pay per office visit; Provider must be in network <i>Facility and other charges for services in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Preventive Services (Subject to frequency limitations determined by the U.S. Preventive Services Task Force and Health Resources and Services Administration)	Paid at 100%, deductible waived Services include: <ul style="list-style-type: none"> • Well child care • Routine physical exams, office visits, x-ray and lab services • Immunizations/vaccinations • Prostate screening and PSA • Diabetes screening • Women’s Preventive Services, including <ul style="list-style-type: none"> ○ office visits and well-women visits ○ mammogram (age 40 and over) ○ gynecological exam ○ Pap smear ○ counseling for sexually transmitted infections ○ human papillomavirus (HPV) testing ○ counseling/screening for HIV, domestic violence, contraceptive methods ○ sterilization procedures ○ screening for gestational diabetes in pregnant women ○ breastfeeding support, supplies, and counseling in conjunction with each birth • Screening colonoscopy or flexible sigmoidoscopy with no medical diagnosis; subject to age/frequency limitations set by USPSTF • Health risk screening, which includes CMP, LP, CBC, TSH, Vit D and blood pressure screening; one per benefit period 	
Professional Provider Services	Deductible and co-insurance apply, unless visit falls under primary care co-pay	
Maternity Benefits	Deductible and co-insurance apply, except for routine prenatal office visits at participating provider (see below) Routine prenatal office visits with participating provider are covered as follows: <ul style="list-style-type: none"> • 40% of covered expenses of global maternity fee paid at 100% deductible waived OR • 100% of routine prenatal office visits if billed separately 	
Emergency Room	Deductible and co-insurance apply	
Alternative Care	Deductible and co-insurance apply \$500 combined yearly benefit for medically necessary chiropractic/spinal manipulation, massage therapy, and acupuncture	
Mental Illness	Processed under medical benefits	

TRADITIONAL MEDICAL PLAN OPTION 2 – Continued

Chemical Dependency	Processed under medical benefits
Home Health Care	Up to 40 visits per benefit period
Habilitative/Rehabilitative Therapy	Includes physical, occupational, and speech therapy Requires order by physician
<p>Prescription Drugs</p> <p>(Only available through preferred providers)</p> <p>See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com</p>	<p>Retail pharmacy (for a 30-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Name Formulary - \$45 copay, no deductible applies • Brand Name Non-Formulary – 35% coinsurance, no deductible applies <p>Retail/Mail Order pharmacy (for a 90-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Name Formulary - \$90 copay, no deductible applies • Brand Name Non-Formulary – 35% coinsurance, no deductible applies <p>Specialty Medications</p> <ul style="list-style-type: none"> • Generic Specialty Drugs - \$15 copay, no deductible applies • Brand Specialty Drugs - \$200 copay, no deductible applies • Examples include high-cost injectables, infused, oral or inhaled medications prescribed for chronic disease conditions • Covered under Lumicera Health Services Specialty Pharmacy • For information call 1-855-847-3553

TRADITIONAL MEDICAL PLAN OPTION 3

Benefit Period	Calendar Year (January 1 – December 31)	
Deductible (An individual covered person cannot receive credit toward the family deductible for more than the individual annual deductible amount.)	Individual - \$7,000	Family - \$14,000
Co-Insurance	60/40	
Maximum Out-of-Pocket	\$8,500 Individual/\$17,000 Family (includes the deductible)	
Out-of-Network	<ul style="list-style-type: none"> • Subject to separate deductible and co-insurance amount • Co-insurance level will also be reduced to 50/50 	
BENEFIT HIGHLIGHTS		
Medical benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)		
Deductible and co-insurance apply to all services listed below, unless noted otherwise. Benefits and general provisions described herein are only a summary and are subject to the terms of the Summary Plan Document.		
Primary Care Co-Pay	\$35 per office visit; Provider must be in network <i>Services provided in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Urgent Care	\$75 co-pay per office visit; Provider must be in network <i>Facility and other charges for services in connection with the office visit including, but not limited to, laboratory services and x-rays, will apply to Deductible and Co-insurance</i>	
Preventive Services (Subject to frequency limitations determined by the U.S. Preventive Services Task Force and Health Resources and Services Administration)	Paid at 100%, deductible waived Services include: <ul style="list-style-type: none"> • Well child care • Routine physical exams, office visits, x-ray and lab services • Immunizations/vaccinations • Prostate screening and PSA • Diabetes screening • Women’s Preventive Services, including <ul style="list-style-type: none"> ○ office visits and well-women visits ○ mammogram (age 40 and over) ○ gynecological exam ○ Pap smear ○ counseling for sexually transmitted infections ○ human papillomavirus (HPV) testing ○ counseling/screening for HIV, domestic violence, contraceptive methods ○ sterilization procedures ○ screening for gestational diabetes in pregnant women ○ breastfeeding support, supplies, and counseling in conjunction with each birth • Screening colonoscopy or flexible sigmoidoscopy with no medical diagnosis; subject to age/frequency limitations set by USPSTF • Health risk screening, which includes CMP, LP, CBC, TSH, Vit D and blood pressure screening; one per benefit period 	
Professional Provider Services	Deductible and co-insurance apply, unless visit falls under primary care co-pay	
Maternity Benefits	Deductible and co-insurance apply, except for routine prenatal office visits at participating provider (see below) Routine prenatal office visits with participating provider are covered as follows: <ul style="list-style-type: none"> • 40% of covered expenses of global maternity fee paid at 100% deductible waived OR • 100% of routine prenatal office visits if billed separately 	
Emergency Room	Deductible and co-insurance apply	
Alternative Care	Deductible and co-insurance apply \$500 combined yearly benefit for medically necessary chiropractic/spinal manipulation, massage therapy, and acupuncture	
Mental Illness	Processed under medical benefits	
Chemical Dependency	Processed under medical benefits	
Home Health Care	Up to 40 visits per benefit period	

TRADITIONAL MEDICAL PLAN OPTION 3 – Continued

Habilitative/Rehabilitative Therapy	Includes physical, occupational, and speech therapy Requires order by physician
Prescription Drugs (Only available through preferred providers) See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com	Retail pharmacy (for a 30-day supply) <ul style="list-style-type: none">• Generic - \$15 copay, no deductible applies• Brand Name Formulary - \$45 copay, no deductible applies• Brand Name Non-Formulary – 35% coinsurance, no deductible applies Retail/Mail Order pharmacy (for a 90-day supply) <ul style="list-style-type: none">• Generic - \$15 copay, no deductible applies• Brand Name Formulary - \$90 copay, no deductible applies• Brand Name Non-Formulary – 35% coinsurance, no deductible applies Specialty Medications <ul style="list-style-type: none">• Generic Specialty Drugs - \$15 copay, no deductible applies• Brand Specialty Drugs - \$200 copay, no deductible applies• Examples include high-cost injectables, infused, oral or inhaled medications prescribed for chronic disease conditions• Covered under Lumicera Health Services Specialty Pharmacy• For information call 1-855-847-3553

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION 1

Benefit Period	Calendar Year (January 1 – December 31)	
Deductible (When coverage other than employee only is elected, the full family deductible will need to be met prior to any reimbursement under the coinsurance provision.)	Individual - \$2,000	Family - \$4,000
Co-Insurance	70/30	
Maximum Out-of-Pocket (*When coverage other than employee only is elected, the out-of-pocket maximum per any one individual will not exceed \$7,000 when using an exclusive/participating provider.)	Individual - \$5,000	Family - \$10,000*
Out-of-Network	<ul style="list-style-type: none"> • Subject to separate deductible and co-insurance amount, equal to 2 times the PPO deductible and co-insurance amount • Co-insurance level will also be reduced to 55/45 	

BENEFIT HIGHLIGHTS

Medical benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)

Deductible and co-insurance apply to all services listed below, unless noted otherwise. Benefits and general provisions described herein are only a summary and are subject to the terms of the Summary Plan Document.

Preventive Services (Subject to frequency limitations determined by the U.S. Preventive Services Task Force and Health Resources and Services Administration)	Paid at 100%, deductible waived Services include: <ul style="list-style-type: none"> • Well child care • Routine physical exams, office visits, x-ray and lab services • Immunizations/vaccinations • Prostate screening and PSA • Diabetes screening • Women’s Preventive Services, including <ul style="list-style-type: none"> ○ office visits and well-women visits ○ mammogram (age 40 and over) ○ gynecological exam ○ Pap smear ○ counseling for sexually transmitted infections ○ human papillomavirus (HPV) testing ○ counseling/screening for HIV, domestic violence, contraceptive methods ○ sterilization procedures ○ screening for gestational diabetes in pregnant women ○ breastfeeding support, supplies, and counseling in conjunction with each birth • Screening colonoscopy or flexible sigmoidoscopy with no medical diagnosis; subject to age/frequency limitations set by USPSTF • Health risk screening, which includes CMP, LP, CBC, TSH, Vit D and blood pressure screening; one per benefit period 	
Preventive Prescription Drugs* *This benefit only applies to certain preventive medications. See below for coverage on all other prescriptions. Only available through preferred providers. See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com	Retail pharmacy (for a 30-day supply) <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Formulary - \$45 copay, no deductible applies • Brand Non-Formulary - 35% coinsurance, no deductible applies Retail/Mail Order pharmacy (for a 90-day supply) <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Formulary - \$90 copay, no deductible applies • Brand Non-Formulary - 35% coinsurance, no deductible applies 	
Professional Provider Services	Deductible and co-insurance apply	
Maternity Benefits	Deductible and co-insurance apply, except for routine prenatal office visits at participating provider (see below) Routine prenatal office visits with participating provider are covered as follows: <ul style="list-style-type: none"> • 40% of covered expenses of global maternity fee paid at 100% deductible waived OR • 100% of routine prenatal office visits if billed separately 	
Emergency Room	Deductible and co-insurance apply	

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION 1 – Continued

Alternative Care	Deductible and co-insurance apply \$500 combined yearly benefit for medically necessary chiropractic/spinal manipulation, massage therapy, and acupuncture
Mental Illness	Processed under medical benefits
Chemical Dependency	Processed under medical benefits
Home Health Care	Up to 40 visits per benefit period
Habilitative/Rehabilitative Therapy	Includes physical, occupational, and speech therapy Requires order by physician
Prescription Drugs (Only available through preferred providers) See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com	<p>Retail pharmacy (for a 30-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay after deductible is met • Brand Name Formulary - \$45 copay after deductible is met • Brand Name Non-Formulary - 35% coinsurance after deductible is met <p>Retail/Mail Order pharmacy (for a 90-day supply)</p> <ul style="list-style-type: none"> • Generic - \$15 copay after deductible is met • Brand Name Formulary - \$90 copay after deductible is met • Brand Name Non-Formulary - 35% coinsurance after deductible is met <p>Specialty Medications</p> <ul style="list-style-type: none"> • Subject to deductible and co-insurance • Examples include high-cost injectables, infused, oral or inhaled medications prescribed for chronic disease conditions • Covered under Lumicera Health Services Specialty Pharmacy • For information call 1-855-847-3553

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION 2

Benefit Period	Calendar Year (January 1 – December 31)	
Deductible (This plan has an embedded deductible, which means when coverage other than employee only is elected, a covered family member only needs to satisfy the individual deductible prior to the Plan paying benefits for that individual.)	Individual - \$6,000	Family - \$12,000
Co-Insurance	PPO 100/0	Non-PPO 85/15
Maximum Out-of-Pocket	Amount of Deductible	
Out-of-Network	<ul style="list-style-type: none"> • Unlimited • Subject to separate deductible equal to 2 times the PPO deductible • Co-insurance level will also be reduced to 85/15 	

BENEFIT HIGHLIGHTS

Medical benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)

Deductible and co-insurance apply to all services listed below, unless noted otherwise. Benefits and general provisions described herein are only a summary and are subject to the terms of the Summary Plan Document.

Preventive Services (Subject to frequency limitations determined by the U.S. Preventive Services Task Force and Health Resources and Services Administration)	Paid at 100%, deductible waived Services include: <ul style="list-style-type: none"> • Well child care • Routine physical exams, office visits, x-ray and lab services • Immunizations/vaccinations • Prostate screening and PSA • Diabetes screening • Women’s Preventive Services, including <ul style="list-style-type: none"> ○ office visits and well-women visits ○ mammogram (age 40 and over) ○ gynecological exam ○ Pap smear ○ counseling for sexually transmitted infections ○ human papillomavirus (HPV) testing ○ counseling/screening for HIV, domestic violence, contraceptive methods ○ sterilization procedures ○ screening for gestational diabetes in pregnant women ○ breastfeeding support, supplies, and counseling in conjunction with each birth • Screening colonoscopy or flexible sigmoidoscopy with no medical diagnosis; subject to age/frequency limitations set by USPSTF • Health risk screening, which includes CMP, LP, CBC, TSH, Vit D and blood pressure screening; one per benefit period 	
Preventive Prescription Drugs* *This benefit only applies to certain preventive medications. See below for coverage on all other prescriptions. Only available through preferred providers. See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com	Retail pharmacy (for a 30-day supply) <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Formulary - \$45 copay, no deductible applies • Brand Non-Formulary - 35% coinsurance, no deductible applies Retail/Mail Order pharmacy (for a 90-day supply) <ul style="list-style-type: none"> • Generic - \$15 copay, no deductible applies • Brand Formulary - \$90 copay, no deductible applies • Brand Non-Formulary - 35% coinsurance, no deductible applies 	
Professional Provider Services	Deductible and co-insurance apply	
Maternity Benefits	Deductible and co-insurance apply, except for routine prenatal office visits at participating provider (see below) Routine prenatal office visits with participating provider are covered as follows: <ul style="list-style-type: none"> • 40% of covered expenses of global maternity fee paid at 100% deductible waived OR • 100% of routine prenatal office visits if billed separately 	
Emergency Room	Deductible and co-insurance apply	
Alternative Care	Deductible and co-insurance apply \$500 combined yearly benefit for medically necessary chiropractic/spinal manipulation, massage therapy, and acupuncture	

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION 2 - Continued

Mental Illness	Processed under medical benefits
Chemical Dependency	Processed under medical benefits
Home Health Care	Up to 40 visits per benefit period
Habilitative/Rehabilitative Therapy	Includes physical, occupational, and speech therapy Requires order by physician
Prescription Drugs (Only available through preferred providers) See Costco Mail Order Flyer for details: Phone: 800-607-6861 Online: pharmacy.costco.com .	Retail pharmacy (for a 30-day supply) <ul style="list-style-type: none"> • Generic - \$0 copay after deductible is met • Brand Formulary - \$0 copay after deductible is met • Brand Non-Formulary - 0% coinsurance after deductible is met Retail/Mail Order pharmacy (for a 90-day supply) <ul style="list-style-type: none"> • Generic - \$0 copay after deductible is met • Brand Formulary - \$0 copay after deductible is met • Brand Non-Formulary - 0% coinsurance after deductible is met Specialty Medications <ul style="list-style-type: none"> • Subject to deductible and co-insurance • Examples include high-cost injectables, infused, oral or inhaled medications prescribed for chronic disease conditions • Covered under Lumicera Health Services Specialty Pharmacy • For information call 1-855-847-3553

RECURO HEALTH TELEMEDICINE OPTION

Telemedicine Benefit	<ul style="list-style-type: none"> • 24/7 Telemedicine Benefit through Recuro Health • Can be added to any of the Medical Plans • Employer pays a \$2.50 PEPM administration fee • 24/7 Telemedicine Benefit through Recuro Health • \$35 co-pay, deductible waived • Available to all members in the household regardless of whether covered on the medical plan
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NETWORK¹



- PPO Network for participants who reside outside of Montana

To view PPO Provider Directory

Visit www.associatedemployers.org

Click on Insurance/Benefits tab

Click on PPO/Networks Link

Click on name of network

¹Services rendered by non-PPO providers are reimbursed at the Allowable Charge as defined in the Summary Plan Description.

LIFE INSURANCE BENEFIT

Minimum of \$5,000 required with Medical Plan

Employee Coverage	Employer's Choice \$5,000 minimum required with medical coverage Available in \$5,000 increments, up to maximum of \$50,000
Spouse Coverage (Optional)	\$2,000
Dependent Children (Optional)	\$1,000 Up to 26 years of age
Conversion	May convert to individual policy when leaving employment
Accelerated Death Benefit	Available on Employee only, if insured for at least \$10,000 (80% of amount in force, minimum of \$3,000)

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Only available on employee coverage

Accidental Death	Amount equal to the amount of life insurance in force for employee
Separate Provision	Life insurance benefit not reduced by any other AD&D benefits
Loss of Limbs, Sight, Hearing, Movement	Percentage of principal sum (life insurance amount)
Seat Belt Benefit	10% of principal sum in event of motor vehicle accidental death
Education Benefit	Lesser of \$3,000 or 100% of principal sum or actual one year tuition per student dependent

The life and accidental death & dismemberment coverage is an insured product through Hartford Life.

DENTAL PLAN OPTION – No Ortho

Dental benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)

Benefit Period	Calendar Year (January 1 – December 31)
Plan	<p>Non-Voluntary Enrollment</p> <ul style="list-style-type: none"> • Coverage is on all lives covered on the medical plan <p>Voluntary Enrollment</p> <ul style="list-style-type: none"> • Allows employee to elect or waive coverage; if coverage is elected, dependents can be added regardless of whether covered on medical plan
Deductible (Family deductible equals maximum of 3x individual deductible, with no more than individual deductible being satisfied by one person)	\$25 per individual
Maximum Benefit Amount	\$1,500 per benefit period
Type A – Preventive Care	<p>100% after deductible</p> <ul style="list-style-type: none"> • Oral Examination (periodic) two times per calendar year • Oral Examination (full mouth) once every five years • Prophylaxis, (cleaning) 2 times per calendar year • Topical Application of fluoride for children < 15 • Dental x-rays, some limitations apply • Space maintainers for children < 12 years of age • Topical application of sealant, children < 16, once a year
Type B – Basic Care	<p>80% after deductible</p> <ul style="list-style-type: none"> • Extractions (non-orthodontic) • Restorative type fillings • General & local anesthetic. • Treatment of periodontal and other diseases of the gums • Endodontic treatment, including root canal • Injection of antibiotic drugs • Re-cementing of crowns, inlays and bridgework • Relining of dentures every two years • Emergency palliative treatment
Type C – Major Restorative	<p>50% after deductible</p> <ul style="list-style-type: none"> • Must be covered under the Plan for 6 consecutive months before benefits are payable for Type C care • Inlays, onlays, gold fillings or crowns • Initial installation of fixed bridgework • Initial installation of partial or full removable dentures • Replacement of existing bridgework • Replacement of existing partial or full removable denture • Dental Implants (medically necessary, not for cosmetic reasons)

DENTAL PLAN OPTION – With Ortho

Dental benefits are provided through a partially self-funded multiple employer welfare arrangement (MEWA)

Benefit Period	Calendar Year (January 1 – December 31)
Plan	<p>Non-Voluntary Enrollment</p> <ul style="list-style-type: none"> Coverage is on all lives covered on the medical plan <p>Voluntary Enrollment</p> <ul style="list-style-type: none"> Allows employee to elect or waive coverage; if coverage is elected, dependents can be added regardless of whether covered on medical plan
Deductible (Family deductible equals maximum of 3x individual deductible, with no more than individual deductible being satisfied by one person)	\$50 per individual
Maximum Benefit Amount	<p>\$1,500 per benefit period</p> <p>Orthodontia not included in annual maximum benefit amount</p>
Type A – Preventive Care	<p>100% after deductible</p> <ul style="list-style-type: none"> Oral Examination (periodic) two times per calendar year Oral Examination (full mouth) once every five years Prophylaxis, (cleaning) 2 times per calendar year Topical Application of fluoride for children < 15 Dental x-rays, some limitations apply Space maintainers for children < 12 years of age Topical application of sealant, children < 16, once a year
Type B – Basic Care	<p>80% after deductible</p> <ul style="list-style-type: none"> Extractions (non-orthodontic) Restorative type fillings General & local anesthetic. Treatment of periodontal and other diseases of the gums Endodontic treatment, including root canal Injection of antibiotic drugs Re-cementing of crowns, inlays and bridgework Relining of dentures every two years Emergency palliative treatment
Type C – Major Restorative	<p>50% after deductible</p> <ul style="list-style-type: none"> Must be covered under the Plan for 6 consecutive months before benefits are payable for Type C care Inlays, onlays, gold fillings or crowns Initial installation of fixed bridgework Initial installation of partial or full removable dentures Replacement of existing bridgework Replacement of existing partial or full removable denture Dental Implants (medically necessary, not for cosmetic reasons)
Type D – Orthodontics	<p>50% after deductible</p> <ul style="list-style-type: none"> For dependent children up to age 19 Orthodontia Lifetime Maximum \$1,500 Must be covered under the Plan for 6 consecutive months before benefits are payable for Type D care Charges of a dentist for treatment, material and supplies furnished in connection with orthodontic treatment

VISION PLAN (Provided through VSP) OPTION

Benefit Period	Calendar Year (January 1 – December 31)
Plan	<p>Non-Voluntary Enrollment</p> <ul style="list-style-type: none"> Coverage is on all lives covered on the medical plan <p>Voluntary Enrollment</p> <ul style="list-style-type: none"> Allows employee to elect or waive coverage; if coverage is elected, dependents can be added regardless of whether covered on medical plan
WellVision Exam (Allowed every calendar year)	<p>\$10 copay</p> <p>Up to \$39 copay for routine retinal screening</p>
Prescription Glasses	\$25 copay - includes frames/lenses
Frames (Allowed every other calendar year)	<ul style="list-style-type: none"> \$200 allowance for a wide selection of frames \$220 allowance for featured frame brands 20% savings on amount over your allowance \$110 Costco® Walmart® Sam's Club® frame allowance
Lenses (Allowed every calendar year)	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children
Lens Enhancements (Allowed every calendar year)	<ul style="list-style-type: none"> \$0 for Standard progressive lenses \$80-\$90 for Premium progressive lenses \$120-\$160 for Custom progressive lenses Average savings of 40% on other lens enhancements
Contacts (In lieu of glasses) (Allowed every calendar year)	<ul style="list-style-type: none"> \$200 allowance for contacts Up to \$60 copay for contact lens exam (fitting/evaluation)
Essential Medical Eye Care	<ul style="list-style-type: none"> \$0 copay for Retinal imaging for members with diabetes \$20 per exam for services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma and more Coordination with medical coverage may apply Ask your VSP doctor for details
VSP Lightcare™ (Allowed every other calendar year) (Not available at Walmart®/Sam's Club®)	<ul style="list-style-type: none"> \$25 copay \$200 allowance or \$110 Costco® allowance Use for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts
Additional Savings	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> 30% savings on additional glasses/sunglasses, including lens enhancements, from the same VSP doctor on the same day as your WellVision Exam OR 20% savings on additional glasses/sunglasses from any VSP doctor within 12 months of your last WellVision Exam <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price Discounts only available from contracted facilities <p>Exclusive Member Extras</p> <ul style="list-style-type: none"> Discover all current eyewear offers and savings at vsp.com/offers Save up to 60% on digital hearing aids with TruHearing®. For details, to go vsp.com/offers/special-offers/hearing-aids
Network	VSP Signature; log in to vsp.com to find an in-network provider
Coverage with non-VSP Providers	For information on non-VSP provider coverage, visit vsp.com

MONTHLY LIFE INSURANCE RATES

Provided by Hartford Life

Employee Life

(Minimum of \$5,000 attached to each employee on medical plan)

\$5,000	\$1.35 PEPM
\$10,000	\$2.70 PEPM
\$15,000	\$4.05 PEPM
\$20,000	\$5.40 PEPM
\$25,000	\$6.75 PEPM
\$30,000	\$8.10 PEPM
\$35,000	\$9.45 PEPM
\$40,000	\$10.80 PEPM
\$45,000	\$12.15 PEPM
\$50,000	\$13.50 PEPM

Optional Basic Spouse/Dependent Life

(Rate per month to cover spouse/dependents on medical plan)

Spouse \$2,000/Child \$1,000	\$0.48 per month for both
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OPTIONAL BENEFIT RATES

MONTHLY DENTAL INSURANCE RATES

\$25 Deductible (without Orthodontia)

	Non-Voluntary Enrollment Must enroll 100% of eligible medical lives.	Voluntary Enrollment Minimum of 5 employees or 100% of eligible employees, whichever is less
Employee Only	\$32.00	\$41.50
Employee/Spouse	\$60.50	\$78.75
Employee/Child(ren)	\$61.00	\$79.50
Employee/Family	\$89.75	\$116.50

MONTHLY DENTAL INSURANCE RATES

\$50 Deductible (with Orthodontia)

	Non-Voluntary Enrollment Must enroll 100% of eligible medical lives.	Voluntary Enrollment Minimum of 5 employees or 100% of eligible employees, whichever is less
Employee Only	\$29.50	\$38.25
Employee/Spouse	\$56.00	\$72.50
Employee/Child(ren)	\$67.50	\$87.50
Employee/Family	\$93.75	\$121.75

MONTHLY VISION INSURANCE RATES

Provided by VSP (Vision Service Plan)

	Non-Voluntary Enrollment Must enroll 100% of eligible medical lives.	Voluntary Enrollment Minimum of 5 employees or 100% of eligible employees, whichever is less
Employee Only	\$9.77	\$10.65
Employee/Spouse	\$15.56	\$17.05
Employee/Child(ren)	\$15.90	\$17.37
Employee/Family	\$25.64	\$28.07