Since 1989 The Printing Industry Benefits Trust has been offering and supporting employee benefits insurance for companies from 2 to 500 employees in the printing, graphic arts and web media industries. Our mission is to present solutions that help control costs while delivering meaningful healthcare benefits and to be a trusted source of support and assistance.

- **Industry leading service center - one call for service and support**
- **No cost COBRA Administration**
- **No cost Section 125 Premium Only Plan Document**
- **Access to full Flexible Spending Account (Section 125 Cafeteria Plan)**

MEDICAL	Kaiser Permanente, PIBT freedom
DENTAL	Delta Dental, Humana
VISION	EyeMed, VSP vision care
LIFE: BASIC & VOLUNTARY	Symetra
EMPLOYEE ASSISTANCE PROGRAM	TELUS Health
EXECUTIVE MEDICAL REIMBURSEMENT PLAN	Ultimate Health by ArmadaCare
VOLUNTARY BENEFITS	Aflac *
FLEX SPENDING ACCOUNT	TASC *

** Billed separately*

Benefits at a Glance

Kaiser		
Plan Name	KP HMO 50/55 (117)	KP Ded HMO 2000 (121)
Network	Full	Full
Calendar Year Deductible (Individual/Family)	Not Applicable	$2,000 [2] / $4,000 [2]
Out-of-pocket maximum (Individual/Family)	$6,350 / $12,700	$4,500 / $9,000
Office Visit (PCP)	$50 Copay	$30 Copay (No Deductible)
Specialist Visit	$55 Copay	$40 Copay (No Deductible)
Outpatient Surgery/Treatment	$250 Copay	No Charge (After Deductible)
Hospital Admission	$1,500 Copay per admission	No Charge (After Deductible)
X-ray	No Charge [42]	No Charge (No Deductible)
Laboratory	No Charge [42]	No Charge (No Deductible)
Urgent Care	$50 Copay	$60 Copay (No Deductible)
Emergency Room	$250 Copay per visit	$250 Copay per visit (No Deductible)
Preventive Care	No Charge	No Charge (No Deductible)
Mental Health Office Visit	$50 Copay	$30 Copay (No Deductible)
Prescription Drugs	**Generic / Brand / Specialty**	**Generic / Brand / Specialty**
Separate calendar year deductible	$100 Individual / $300 Family (Brand only)	Subject to Plan Deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30 day supply)	$35 / $45 / Not Covered	$15 / $45 / 20% up to $300 max
Mail order (up to 90-day supply)	$70 / $90 / Not Covered	$30 / $90 /20%
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	$55 Copay (at Kaiser facility)	$30 Copay (at Kaiser facility)
Frames and lenses	$150 allowance every 12 months (with EyeMed Network)	$150 allowance every 12 months (with EyeMed Network)
Plan ID	6952	11343

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [42] $250 in outpatient settings.

Benefits at a Glance

Kaiser	
Plan Name	KP Ded HMO 3000 (122)
Network	Full
Calendar Year Deductible (Individual/Family)	$3,000 [2] / $6,000 [2]
Out-of-pocket maximum (Individual/Family)	$5,500 / $11,000
Office Visit (PCP)	$40 Copay (No Deductible)
Specialist Visit	$50 Copay (No Deductible)
Outpatient Surgery/Treatment	No Charge (After Deductible)
Hospital Admission	No Charge (After Deductible)
X-ray	No Charge (No Deductible)
Laboratory	No Charge (No Deductible)
Urgent Care	$80 Copay (No Deductible)
Emergency Room	$250 Copay per visit (No Deductible)
Preventive Care	No Charge (No Deductible)
Mental Health Office Visit	$40 Copay (No Deductible)
Prescription Drugs	**Generic / Brand / Specialty**
Separate calendar year deductible	Subject to Plan Deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable
Retail prescriptions (30 day supply)	$15 / $45 / 20% up to $300 max
Mail order (up to 90-day supply)	$30 / $90 /20%
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	$40 Copay (at Kaiser facility)
Frames and lenses	$150 allowance every 12 months (with EyeMed Network)
Plan ID	11344

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan.

Kaiser Monthly Rates by age, effective 12/1/2023

Dependent monthly rates do not include the employee portion.

Plan Name	KP HMO 50/55 (117), Plan ID #6952						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	443.19	509.23	641.30	814.60	1,022.77	1,251.76	1,251.76
+Spouse	518.03	592.87	746.98	947.84	1,193.48	1,464.08	1,464.08
+Child(ren)	353.64	406.44	512.13	650.82	817.36	992.19	992.19
+Spouse & Child(ren)	930.38	1,071.28	1,348.65	1,712.47	2,149.62	2,628.41	2,628.41
Plan Name	**KP Ded HMO 2000 (121), Plan ID #11343**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	473.07	543.59	684.60	869.64	1,091.91	1,336.38	1,336.38
+Spouse	552.98	632.88	797.42	1,011.88	1,274.16	1,563.09	1,563.09
+Child(ren)	377.34	433.75	546.56	694.66	872.44	1,059.15	1,059.15
+Spouse & Child(ren)	993.13	1,143.57	1,439.71	1,828.20	2,294.92	2,806.11	2,806.11
Plan Name	**KP Ded HMO 3000 (122), Plan ID #11344**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	409.51	470.51	592.48	752.46	944.67	1,156.12	1,156.12
+Spouse	478.64	547.75	690.02	875.48	1,102.29	1,352.18	1,352.18
+Child(ren)	327.14	375.93	473.48	601.52	755.30	916.76	916.76
+Spouse & Child(ren)	859.71	989.77	1,245.89	1,581.81	1,985.48	2,427.59	2,427.59

PIBT freedom -FAQ

This Q&A answers the most frequently asked questions about the PIBT Freedom Plans.

1. **PIBT Freedom Plans the right choice for me?**
   These plans are a good choice for you if:
   - You want to control your costs.
   - You prefer to choose your provider.
   - You like the idea of having an advocate help you navigate the healthcare system.
   - You are willing engage with your health plan occasionally.
2. **Who administers the PIBT Freedom Plans?**
   PIBT designed the plans and their benefits and engaged Imagine360 to administer and manage claims under the Freedom Plans.
   - Imagine360 is a third-party administrator who manages claims and provides support teams to advise members through their concierge service and HealthWatch.
   - Imagine360 audits and settles claims from facilities such as hospitals and outpatient centers. In all cases, the staff of PIBT is always here to assist you. Never hesitate to call us.
3. **What doctors and other healthcare providers can I use?**
   Virtually all practitioners accept our plan. Although the Plans use a national network, MultiPlan Practitioner and Ancillary network, that includes physicians, labs, urgent care, and similar types of providers. Your benefits are the same whether you seek care from a preferred or non-preferred practitioner.
   If you are looking for a new doctor, we recommend that you check the MultiPlan Practitioner and Ancillary network and select a suitable doctor from the list. You may also ask Imagine36o's concierge service to find the top practitioners in your area to address your medical issue.
   If you know which doctor you want to see and the provider is non-preferred, bring along your new ID card and your PIBT Practitioner Guidance Flyer. If the provider still has questions, ask them to call Imagine360. An explanation of how our plan works will be given to your provider.
   For facilities like hospitals, outpatient facilities, and surgical centers, the plan does not use a network. You may go to virtually any facility you choose. If the facility needs to contact Imagine360 to confirm your coverage or other information, the contact information is on your Freedom plan ID card. If you like, you may contact Imagine360 prior to any appointment and they will contact the doctor or facility to make sure there are no challenges when you arrive for your appointment.
   Note that certain healthcare providers and facilities, Kaiser for example, only treat patients who are part of their health system. Kaiser will typically not accept the PIBT Freedom Plans except for emergency medical conditions.
4. **What if a healthcare provider says they do not recognize my insurance plan?**
   Give them the PIBT Practitioner Guidance Flyer which should answer their questions. If they still have questions, ask them to call Imagine360 at the number on your ID card. We are almost always able to work out a solution for you and get you seen and treated. Although very rare, if a solution cannot be found with your provider, a member of the concierge service team will locate other top-tier provider options for you to select from for your medical services.

5. What if a healthcare provider asks me to pay upfront?

Call Imagine360 immediately, even if you are in the provider's office. You should not pay any amounts higher than your plan co-pay, coinsurance or deductible, depending on the type of treatment you are receiving. We will explain to the provider how our plan works and get you seen without an upfront payment higher than these amounts.

Who can I turn to with questions or for help? The staff at PIBT can answer many of your questions related to eligibility, benefits and various administrative issues. Imagine360 also has Member Service Professionals who are available to answer more detailed questions. One of the most valued resources provided under the Freedom Plans is Imagine360 's concierge service. These advocates are available to help you:

- Navigate the complex healthcare system;
- Find the best healthcare providers in your area;
- Better understand a diagnosis and learn about treatment options;
- Ensure your physician's office understands the plan and you get seen;
- And much more

6. What happens if a healthcare provider bills me for the balance after I have paid my portion?

This is known as a "Balance Bill" and does it does not happen very often but, if you receive a balance bill, send it to us or Imagine360 directly as soon as possible. You will be contacted within 24 hours by an Imagine360 Member Advocate who will work closely with you until the Balance Bill is resolved.

Our commitment to you is that, if you follow our process, you will only be responsible for co-pays, deductibles and co-insurance based on your Freedom plan. If the bill is sent to collections, your assigned legal representative will contact the collection agency to remove you from the process, and then work with the collection agency to resolve the billing so that your credit is not compromised.

7. Are these plans HMOs, PPOs or POS plans?

These plans are PPO level benefits, but you can seek care at virtually any provider. The MultiPlan Practitioner and Ancillary network gives you an excellent starting point. You can check to see if your current doctor is in the MultiPlan network, or you can find a new doctor, but ultimately you are free to seek care at any provider that you choose.

Benefits at a Glance

PIBT Freedom		
Plan Name	PIBT 35/1250	PIBT 40/1750
Network	Not Applicable [37]	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$1,250 / $2,500 [2]	$1,750 / $3,500 [2]
Out-of-pocket maximum (Individual/Family)	$4,500 / $9,000	$6,000 / $12,000
Office Visit (PCP)	$35 (No Deductible) [40]	$40 (No Deductible) [40]
Specialist Visit	$35 (No Deductible) [40]	$40 (No Deductible) [40]
Outpatient Surgery/Treatment	10% per visit (After Deductible)	25% per visit (After Deductible)
Hospital Admission	$350 copay + 10% per admission (After Deductible)	$250 copay + 25% per admission (After Deductible)
X-ray	$35 per visit [40] (After Deductible)	$40 per visit [40] (After Deductible)
Laboratory	$35 per visit [40] (After Deductible)	$40 per visit [40] (After Deductible)
Urgent Care	$35 (No Deductible)	$40 (No Deductible)
Emergency Room	$350 copay + 10% per visit (After Deductible)	$250 copay + 25% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)	No Charge (No Deductible)
Mental Health Office Visit	$35 (No Deductible)	$40 (No Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	$275 per member (Except Generic) [5]	$275 per member (Except Generic) [5]
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30-90 day supply)	$15 / $30 / $50 / Specialty Drugs Program [6] [44]	$15 / $30 / $45 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$30 / $60 / $100 / Specialty Drugs Program [6] [44]	$30 / $60 / $90 / Specialty Drugs Program [6] [44]
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	No Charge [8]	No Charge [8]
Frames and lenses	Not Covered	Not Covered
Plan ID	11503	11504

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [5] Accrues toward the calendar year out-of-pocket maximum. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Benefits at a Glance

PIBT Freedom		
Plan Name	PIBT 45/3250	PIBT 55/5500
Network	Not Applicable [37]	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$3,250 / $6,500 [2]	$5,500 / $11,000 [2]
Out-of-pocket maximum (Individual/Family)	$7,500 / $15,000	$8,500 / $17,000
Office Visit (PCP)	$45 (No Deductible) [40]	$55 (No Deductible) [40]
Specialist Visit	$45 (No Deductible) [40]	$55 (No Deductible) [40]
Outpatient Surgery/Treatment	25% per visit (After Deductible)	40% per visit (After Deductible)
Hospital Admission	$250 + 25% per admission (After Deductible)	$250 copay + 40% per admission (After Deductible)
X-ray	$45 per visit [40] (After Deductible)	$55 per visit [40] (After Deductible)
Laboratory	$45 per visit [40] (After Deductible)	$55 per visit [40] (After Deductible)
Urgent Care	$45 (No Deductible)	$55 (No Deductible)
Emergency Room	$250 copay + 25% per visit (After Deductible)	$250 copay + 40% (After Deductible)
Preventive Care	No Charge (No Deductible)	No Charge (No Deductible)
Mental Health Office Visit	$45 (No Deductible)	$55 (No Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	$275 per member (Except Generic) [5]	$275 per member (Except Generic) [5]
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30-90 day supply)	$15 / $30 / $45 / Specialty Drugs Program [6] [44]	$15 / $30 / 50% $100 max [6] / Specialty Drugs Program [44]
Mail order (30-90-day supply)	$30 / $60 / $90 / Specialty Drugs Program [6] [44]	$30 / $60 / 50% $200 max [6] / Specialty Drugs Program [44]
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	No Charge [8]	No Charge [8]
Frames and lenses	Not Covered	Not Covered
Plan ID	11505	11506

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [5] Accrues toward the calendar year out-of-pocket maximum. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Benefits at a Glance

PIBT Freedom	
Plan Name	PIBT HSA 6500
Network	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$6,500 / $13,000 [2]
Out-of-pocket maximum (Individual/Family)	$7,050 / $14,100
Office Visit (PCP)	30% (After Deductible) [40]
Specialist Visit	30% (After Deductible) [40]
Outpatient Surgery/Treatment	30% per visit (After Deductible)
Hospital Admission	$250 + 30% per admission (After Deductible)
X-ray	30% [40] (After Deductible)
Laboratory	30% [40] (After Deductible)
Urgent Care	30% (After Deductible)
Emergency Room	$250 + 30% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)
Mental Health Office Visit	30% (After Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	Subject to the calendar year deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable
Retail prescriptions (30-90 day supply)	$10 / $25 /$40 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$20 / $50 / $80 / Specialty Drugs Program [6] [44]
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	No Charge [8]
Frames and lenses	Not Covered
Plan ID	11507

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

PIBT Freedom Monthly Rates by age, effective 12/1/2023

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT 35/1250				PIBT 40/1750			
Plan ID	11503				11504			
Region	100				100			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family	Employee	+Spouse	+Child(ren)	+Family
18	393.63	511.72	275.54	747.90	363.32	472.32	254.33	690.31
19	393.63	511.72	275.54	747.90	363.32	472.32	254.33	690.31
20	393.63	511.72	275.54	747.90	363.32	472.32	254.33	690.31
21	442.29	574.98	309.61	840.36	408.24	530.71	285.77	775.65
22	450.75	585.98	315.53	856.43	416.05	540.85	291.23	790.49
23	459.83	597.79	321.89	873.69	424.43	551.76	297.10	806.42
24	469.55	610.41	328.68	892.14	433.39	563.41	303.38	823.45
25	479.89	623.85	335.92	911.79	442.93	575.82	310.05	841.59
26	490.85	638.11	343.60	932.63	453.05	588.98	317.14	860.81
27	502.49	653.25	351.74	954.75	463.81	602.95	324.66	881.23
28	514.77	669.20	360.33	978.05	475.13	617.67	332.59	902.74
29	527.76	686.10	369.43	1,002.76	487.13	633.27	340.99	925.54
30	541.39	703.82	378.98	1,028.66	499.70	649.63	349.80	949.45
31	555.75	722.48	389.03	1,055.93	512.96	666.85	359.07	974.62
32	570.84	742.10	399.59	1,084.60	526.88	684.96	368.83	1,001.08
33	586.66	762.66	410.67	1,114.66	541.49	703.93	379.04	1,028.83
34	603.27	784.24	422.29	1,146.20	556.81	723.86	389.77	1,057.95
35	620.65	806.86	434.46	1,179.25	572.87	744.72	401.00	1,088.44
36	638.82	830.48	447.18	1,213.77	589.63	766.53	412.75	1,120.30
37	657.83	855.18	460.48	1,249.88	607.17	789.33	425.02	1,153.63
38	677.73	881.03	474.40	1,287.67	625.54	813.20	437.87	1,188.52
39	698.45	907.99	488.92	1,327.06	644.67	838.07	451.27	1,224.88
40	720.07	936.08	504.04	1,368.13	664.62	864.02	465.24	1,262.79
41	742.62	965.41	519.83	1,410.98	685.44	891.07	479.80	1,302.33
42	766.17	996.02	536.32	1,455.73	707.17	919.33	495.02	1,343.63
43	790.66	1,027.86	553.46	1,502.25	729.78	948.71	510.84	1,386.57
44	816.19	1,061.05	571.33	1,550.77	753.34	979.35	527.34	1,431.35
45	842.77	1,095.59	589.94	1,601.26	777.87	1,011.24	544.52	1,477.97
46	870.44	1,131.57	609.30	1,653.83	803.41	1,044.45	562.39	1,526.49
47	899.20	1,168.98	629.45	1,708.50	829.96	1,078.97	580.98	1,576.94
48	929.12	1,207.87	650.39	1,765.34	857.58	1,114.86	600.31	1,629.40
49	960.20	1,248.24	672.13	1,824.36	886.25	1,152.14	620.38	1,683.89
50	992.51	1,290.27	694.76	1,885.78	916.09	1,190.91	641.26	1,740.56
51	1,026.08	1,333.91	718.26	1,949.57	947.08	1,231.20	662.96	1,799.45
52	1,060.97	1,379.24	742.67	2,015.82	979.27	1,273.05	685.49	1,860.60
53	1,097.15	1,426.28	768.00	2,084.58	1,012.66	1,316.48	708.87	1,924.07
54	1,134.74	1,475.16	794.32	2,156.00	1,047.37	1,361.58	733.15	1,989.99
55	1,173.74	1,525.87	821.62	2,230.12	1,083.36	1,408.37	758.36	2,058.39
56	1,214.20	1,578.47	849.94	2,306.99	1,120.71	1,456.92	784.50	2,129.36
57	1,256.19	1,633.03	879.33	2,386.75	1,159.46	1,507.30	811.62	2,202.97
58	1,299.68	1,689.58	909.78	2,469.39	1,199.61	1,559.49	839.72	2,279.25
59	1,344.79	1,748.23	941.35	2,555.10	1,241.24	1,613.63	868.87	2,358.37
60	1,391.58	1,809.04	974.10	2,643.99	1,284.43	1,669.74	899.09	2,440.40
61	1,440.03	1,872.03	1,008.01	2,736.05	1,329.15	1,727.89	930.39	2,525.37
62	1,490.21	1,937.26	1,043.14	2,831.39	1,375.45	1,788.10	962.82	2,613.37
63	1,542.21	2,004.86	1,079.54	2,930.19	1,423.45	1,850.50	996.42	2,704.57
64+	1,611.97	2,095.56	1,128.37	3,062.73	1,487.85	1,934.19	1,041.48	2,826.90

PIBT Freedom Monthly Rates by age, effective 12/1/2023

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT 45/3250				PIBT 55/5500			
Plan ID	11505				11506			
Region	100				100			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family	Employee	+Spouse	+Child(ren)	+Family
18	318.06	413.47	222.63	604.30	285.38	371.00	199.77	542.23
19	318.06	413.47	222.63	604.30	285.38	371.00	199.77	542.23
20	318.06	413.47	222.63	604.30	285.38	371.00	199.77	542.23
21	357.38	464.58	250.16	679.01	320.67	416.86	224.45	609.25
22	364.21	473.47	254.95	691.99	326.79	424.84	228.76	620.91
23	371.55	483.01	260.08	705.94	333.38	433.41	233.37	633.43
24	379.40	493.21	265.57	720.85	340.42	442.55	238.30	646.81
25	387.75	504.06	271.42	736.72	347.92	452.30	243.54	661.04
26	396.61	515.59	277.63	753.56	355.87	462.63	249.11	676.15
27	406.02	527.82	284.21	771.43	364.30	473.61	255.03	692.19
28	415.93	540.70	291.15	790.27	373.20	485.17	261.24	709.10
29	426.43	554.36	298.51	810.22	382.64	497.41	267.84	726.99
30	437.45	568.68	306.21	831.14	392.51	510.27	274.77	745.77
31	449.05	583.77	314.34	853.20	402.93	523.79	282.04	765.55
32	461.24	599.61	322.87	876.36	413.86	538.02	289.71	786.34
33	474.02	616.24	331.82	900.65	425.33	552.93	297.72	808.13
34	487.44	633.67	341.21	926.13	437.37	568.58	306.16	831.00
35	501.49	651.93	351.05	952.82	449.97	584.97	314.98	854.95
36	516.17	671.03	361.32	980.73	463.14	602.10	324.21	879.99
37	531.52	690.98	372.07	1,009.90	476.93	620.01	333.85	906.15
38	547.60	711.88	383.32	1,040.44	491.34	638.76	343.95	933.56
39	564.35	733.65	395.05	1,072.26	506.38	658.28	354.46	962.11
40	581.81	756.36	407.28	1,105.45	522.05	678.65	365.43	991.89
41	600.04	780.05	420.03	1,140.08	538.40	699.92	376.88	1,022.97
42	619.07	804.79	433.35	1,176.22	555.47	722.12	388.83	1,055.40
43	638.85	830.50	447.19	1,213.81	573.22	745.20	401.27	1,089.14
44	659.49	857.32	461.63	1,253.01	591.74	769.26	414.22	1,124.30
45	680.95	885.25	476.66	1,293.82	611.01	794.31	427.70	1,160.90
46	703.32	914.31	492.32	1,336.30	631.07	820.39	441.75	1,199.03
47	726.56	944.53	508.60	1,380.47	651.93	847.51	456.34	1,238.66
48	750.73	975.95	525.52	1,426.40	673.61	875.71	471.53	1,279.87
49	775.84	1,008.58	543.08	1,474.08	696.14	904.99	487.30	1,322.67
50	801.95	1,042.53	561.37	1,523.71	719.58	935.44	503.70	1,367.18
51	829.07	1,077.80	580.35	1,575.25	743.91	967.09	520.75	1,413.43
52	857.26	1,114.43	600.07	1,628.79	769.20	999.95	538.44	1,461.48
53	886.49	1,152.44	620.54	1,684.34	795.43	1,034.06	556.80	1,511.32
54	916.87	1,191.93	641.81	1,742.05	822.68	1,069.50	575.89	1,563.11
55	948.38	1,232.90	663.87	1,801.93	850.96	1,106.25	595.67	1,616.83
56	981.08	1,275.40	686.75	1,864.05	880.30	1,144.39	616.22	1,672.57
57	1,015.00	1,319.50	710.50	1,928.50	910.73	1,183.95	637.51	1,730.40
58	1,050.14	1,365.18	735.10	1,995.28	942.27	1,224.94	659.59	1,790.31
59	1,086.59	1,412.56	760.61	2,064.53	974.98	1,267.46	682.48	1,852.45
60	1,124.39	1,461.71	787.07	2,136.34	1,008.89	1,311.55	706.22	1,916.89
61	1,163.54	1,512.61	814.48	2,210.73	1,044.02	1,357.23	730.81	1,983.63
62	1,204.08	1,565.32	842.86	2,287.77	1,080.40	1,404.51	756.27	2,052.76
63	1,246.10	1,619.93	872.27	2,367.60	1,118.10	1,453.53	782.66	2,124.39
64+	1,302.47	1,693.20	911.72	2,474.68	1,168.68	1,519.27	818.07	2,220.48

PIBT Freedom Monthly Rates by age, effective 12/1/2023

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT HSA 6500			
Plan ID	11507			
Region	100			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family
18	253.89	330.06	177.73	482.40
19	253.89	330.06	177.73	482.40
20	253.89	330.06	177.73	482.40
21	285.28	370.87	199.70	542.03
22	290.74	377.95	203.51	552.39
23	296.60	385.57	207.61	563.52
24	302.86	393.71	212.00	575.43
25	309.53	402.39	216.67	588.11
26	316.60	411.57	221.61	601.54
27	324.12	421.34	226.87	615.80
28	332.03	431.63	232.41	630.84
29	340.41	442.53	238.29	646.78
30	349.20	453.96	244.43	663.47
31	358.47	465.99	250.92	681.07
32	368.20	478.64	257.73	699.56
33	378.40	491.91	264.87	718.96
34	389.11	505.84	272.37	739.30
35	400.33	520.41	280.22	760.60
36	412.04	535.65	288.43	782.88
37	424.30	551.58	297.00	806.16
38	437.13	568.27	305.99	830.55
39	450.50	585.64	315.34	855.94
40	464.45	603.77	325.11	882.44
41	478.99	622.70	335.30	910.09
42	494.18	642.43	345.93	938.93
43	509.97	662.97	356.99	968.96
44	526.44	684.38	368.52	1,000.25
45	543.59	706.66	380.51	1,032.80
46	561.43	729.87	393.01	1,066.73
47	579.99	753.98	405.99	1,101.98
48	599.28	779.08	419.51	1,138.65
49	619.32	805.13	433.53	1,176.72
50	640.17	832.22	448.12	1,216.32
51	661.82	860.38	463.28	1,257.47
52	684.32	889.62	479.02	1,300.20
53	707.66	919.96	495.36	1,344.56
54	731.91	951.48	512.33	1,390.63
55	757.06	984.18	529.94	1,438.42
56	783.17	1,018.11	548.21	1,488.01
57	810.24	1,053.32	567.18	1,539.46
58	838.29	1,089.79	586.81	1,592.76
59	867.39	1,127.61	607.17	1,648.03
60	897.57	1,166.84	628.30	1,705.37
61	928.81	1,207.47	650.18	1,764.75
62	961.18	1,249.54	672.82	1,826.24
63	994.72	1,293.15	696.31	1,889.98
64+	1,039.72	1,351.63	727.80	1,975.46

Dental DPO Benefits at a Glance

Plan Features	Humana	Humana
Plan Name	Humana Trad Pref PPO	GA Humana Trad PPO 2
Services Rendered At	**In Network** / **Out of Network**	**In Network** / **Out of Network**
Calendar Year Deductible (Individual/Family)	$50 / $150 [24]	$50 / $150 [24]
Calendar Year Maximum	$1,500 per plan period [22]	$1,000
Waiting Period/Major Services	None	None
Benefit Levels	Contracted Rate / Contracted Allowance	Customary & Reasonable
Preventative Services		
Oral Exams	No Charge (No Deductible)	No Charge (No Deductible)
Cleanings	No Charge (No Deductible)	No Charge (No Deductible)
Bitewing X-rays	No Charge (No Deductible)	No Charge (No Deductible)
Complete X-rays	No Charge (No Deductible)	No Charge (No Deductible)
Basic Services		
Fillings (composite resin)	20%	30%
Oral Surgery	20%	30%
Major Services		
Crowns (high noble)	50%	60%
Orthodontics		
Lifetime Maximum	$1,000 per child	Not Covered
Children up to 19th Birthday	50% (No Deductible)	Not Covered
Adults	Not Covered	Not Covered
Monthly Rates, effective 12/01/2023		
Employee	48.88	37.91
+Spouse	62.28	35.89
+Child	51.96	35.89
+Children	51.96	75.44
+Family	117.16	75.44
Plan ID	9126	6985

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[22] After annual maximum is reached, members receive 30% coinsurance on preventive, basic, and major services for the rest of the plan year (excludes orthodontia). [24] Non-participating dentist can bill you for charges above the amount covered by your dental plan. To ensure you do not receive additional charges , visit a participating PPO network dentist.

Dental DPO Benefits at a Glance

Plan Features	DELTA DENTAL®		DELTA DENTAL®	
Plan Name	Delta DPO Plan 1		Delta DPO Plan 2	
Services Rendered At	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible (Individual/Family)	$25 / $75	$50 / $150 [24]	$50 / $150 [24]	
Calendar Year Maximum	$1,500 per person		$1,500 per person [38]	
Waiting Period/Major Services	None [25]		None [25]	
Benefit Levels	Contracted Rate / Contracted Allowance		Contracted Rate / Contracted Allowance	
Preventative Services				
Oral Exams	No Charge (No Deductible)		No Charge (No Deductible)	
Cleanings	No Charge (No Deductible)		No Charge (No Deductible)	
Bitewing X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Complete X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Basic Services				
Fillings (composite resin)	10%	20%	20%	
Oral Surgery	10%	20%	20%	
Major Services				
Crowns (high noble)	40%	50%	50%	
Orthodontics				
Lifetime Maximum	$1,000		$1,000	
Children up to 19th Birthday	50% (No Deductible) [21]		50% (No Deductible) [21]	
Adults	50% (No Deductible) [21]		Not Covered	
Monthly Rates, effective 12/01/2023				
Employee	64.82		52.16	
+Spouse	60.46		48.58	
+Child	80.75		69.51	
+Children	80.75		69.51	
+Family	160.17		133.76	
Plan ID	10424		10425	

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[21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months. [24] Non-participating dentist can bill you for charges above the amount covered by your dental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist. [25] Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees. [38] Non-Delta Dental PPO dentists: $1,000 per person each calendar year.

Dental DMO Benefits at a Glance

Plan Features	Humana	DELTA DENTAL®
Plan Name	GA Humana EPO 2S	Delta USA 11
Calendar Year Deductible (Individual/Family)	None	None
Calendar Year Maximum	None	None
Waiting Period/Major Services	None	None
Benefit Levels	Fee Schedule [43]	Fee Schedule
Preventative Services		
Oral Exams	No Charge (1 every 6 months)	No Charge
Cleanings	No Charge (1 every 6 months)	No Charge (1 per 6 months)
Bitewing X-rays	No Charge (1 every 6 months)	No Charge
Complete X-rays	No Charge (1 every 36 months)	No Charge (1 every 24 months)
Basic Services		
Fillings (composite resin)	No Charge	No Charge
Oral Surgery	No Charge	$5 Copay [20]
Major Services		
Crowns (high noble)	$466 Copay [29]	$240 Copay
Orthodontics		
Lifetime Maximum	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Children up to 19th Birthday	$2,100 Copay [21]	$1,700 Copay [21]
Adults	$2,300 Copay [21]	$1,900 Copay [21]
Monthly Rates, effective 12/01/2023		
Employee	25.01	18.68
+Spouse	26.54	41.49
+Child	26.54	41.49
+Children	52.74	41.49
+Family	52.74	45.06
Plan ID	6986	11303

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[20] Surgical removal of erupted tooth, impacted tooth, and tooth root. [21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months. [29] Limit one per tooth every eight years. [43] Advantage Plus plans are network-based dental plans that emphasize prevention and cost containment. Members select any participating general dentist in Humana's advantage plus network. Care received from and out-of-network dentist (except emergency care) is not a covered benefit.

Vision Benefits at a Glance

Plan Features		
Plan Name	EyeMed High	EyeMed Base
Plan ID	10423	8763
Provider	EyeMed Provider	EyeMed Provider
Eye Exam	$0 Copay	$0 Copay
Frames	$0 Copay. $200 allowance, 20% off on balance over $200	$0 Copay. $130 allowance, 20% off on balance over $130
Lenses		
Single	$10 Copay	$10 Copay
Bifocal	$10 Copay	$10 Copay
Trifocal	$10 Copay	$10 Copay
Contact Lenses (instead of glasses)	$0 Copay. $200 plan allowance 15% off balance over $200	$0 Copay. $130 plan allowance 15% off balance over $130
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Monthly Rates, effective 12/01/2023		
Employee	8.94	7.02
+Spouse	8.03	6.30
+Child	8.03	6.30
+Children	15.98	12.54
+Family	15.98	12.54
Plan ID	10423	8763

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Vision Benefits at a Glance

Plan Features		
Plan Name	EyeMed Kaiser	VSP Premium
Plan ID	8764	10884
Provider	Kaiser Faciliy and EyeMed Provider [34]	VSP Provider [30]
Eye Exam	Plan office visit copay at Kaiser facility	$10 Copay
Frames	$150 plan allowance, 20% off on balance over $150 for frames, lens and lens options	$20 Copay. $200 plan allowance, 20% off balance over allowance
Lenses		
Single	$150 plan allowance, 20% off on balance over $150	$20 Copay
Bifocal	$150 plan allowance, 20% off on balance over $150	$20 Copay
Trifocal	$150 plan allowance, 20% off on balance over $150	$20 Copay
Contact Lenses (instead of glasses)	$0 Copay. $150 plan allowance 15% off balance over $150	$200 plan allowance [31]
Frequency		
Examination	Once every 12 months	Every 12 months
Frame	Once every 12 months	Every 12 months
Lenses or Contact Lenses	Once every 12 months	Every 12 months
Monthly Rates, effective 12/01/2023		
Employee	0.00	12.74
+Spouse	0.00	3.86
+Child	0.00	3.86
+Children	0.00	14.67
+Family	0.00	14.67
Plan ID	8764	10884

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[30] 20% off for certain materials and services accessed through a VSP provider . [31] Allowance for contacts and contact lens exam (fitting and evaluation). [34] Benefits apply for Kaiser participants only. Plan cannot be added to your plan menu.

Vision Benefits at a Glance

Plan Features	vsp vision care
Plan Name	VSP Standard
Plan ID	10883
Provider	VSP Provider [30]
Eye Exam	$10 Copay
Frames	$20 Copay. $150 plan allowance, 20% off balance over allowance
Lenses	
Single	$20 Copay
Bifocal	$20 Copay
Trifocal	$20 Copay
Contact Lenses (instead of glasses)	$150 plan allowance [31]
Frequency	
Examination	Every 12 months
Frame	Every 24 months
Lenses or Contact Lenses	Every 12 months
Monthly Rates, effective 12/01/2023	
Employee	10.24
+Spouse	2.46
+Child	2.46
+Children	10.75
+Family	10.75
Plan ID	10883

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[30] 20% off for certain materials and services accessed through a VSP provider . [31] Allowance for contacts and contact lens exam (fitting and evaluation).

Basic Group Life and AD&D Benefits at a Glance

Distributed by PIA-SC, Insurance Services Inc.

Plan Features	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the member.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care and Spouse Education benefits.
Value Added Services	
Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Monthly Rates, effective 12/1/2023	
Basic Life $10K	2.78
Basic Life $15K	4.18
Basic Life $20K	5.58
Basic Life $25K	6.98
Basic Life $40K	11.18

IMPORTANT NOTICE: This comparison is provided to help you compare coverage benefits at a glance only. Before making your plan choice, you should refer to the Evidence of Coverage and Plan Contract for a detailed description of coverage benefits and limitations. In the event of any difference between this summary versus the Evidence of Coverage or Plan Contract , the Evidence of Coverage and Plan Contract shall prevail.

Voluntary Life and AD&D Benefits at a Glance

Distributed by PIA-SC, Insurance Services Inc.

Plan Features	
Amount	Increments of $10,000
Maximum Amount	Lesser of $500,000 or 10 x Earnings
Guarantee Issue (GIA)	$120,000 (New Hires only)
Age Reduction (Original Benefit Amount reduced to)	65% at age 70 50% at age 75
Eligibility	Full time employee (of participating employer) and their eligible dependents
Evidence of Insurability (EOI)	EOI is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the GIA.
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the member.
Spouse	
Amount	Increments of $5,000
Maximum Amount	$250,000 not to exceed 100% of employee coverage
Guarantee Issue	$25,000
Child	
Child Amount (Birth to 26 yrs.)	$5,000 or maximum of $10,000

Monthly Employee Rates, effective 12/1/2023

Benefit	$10,000	$50,000	$80,000	$120,000
Under 25	0.60	3.00	4.80	7.20
25-29	0.60	3.00	4.80	7.20
30-34	0.70	3.50	5.60	8.40
35-39	0.90	4.50	7.20	10.80
40-44	1.40	7.00	11.20	16.80
45-49	2.60	13.00	20.80	31.20
50-54	4.50	22.50	36.00	54.00
55-59	8.10	40.50	64.80	97.20
60-64	10.20	51.00	81.60	122.40
65-69	17.60	88.00	140.80	211.20
70-74	31.30	156.50	250.40	375.60
75+	31.30	156.50	250.40	375.60

Employee Assistance Program Benefits at a Glance

Plan Features	TELUS Health
Plan Name	EAP
Employee Assistance Program	Counseling services for various life management problems for employees and dependents
Office Visits	$0 copay with authorization
Deductible	None
Clinical Counseling	
Visits	6 visits per incident per plan period, unlimited incidents
Telephone Couseling	As needed
Web Video Couseling	As needed
Monthly Rates, effective 12/01/2023, Employer Sponsored Plan	
Employee	5.80
Plan ID	11643

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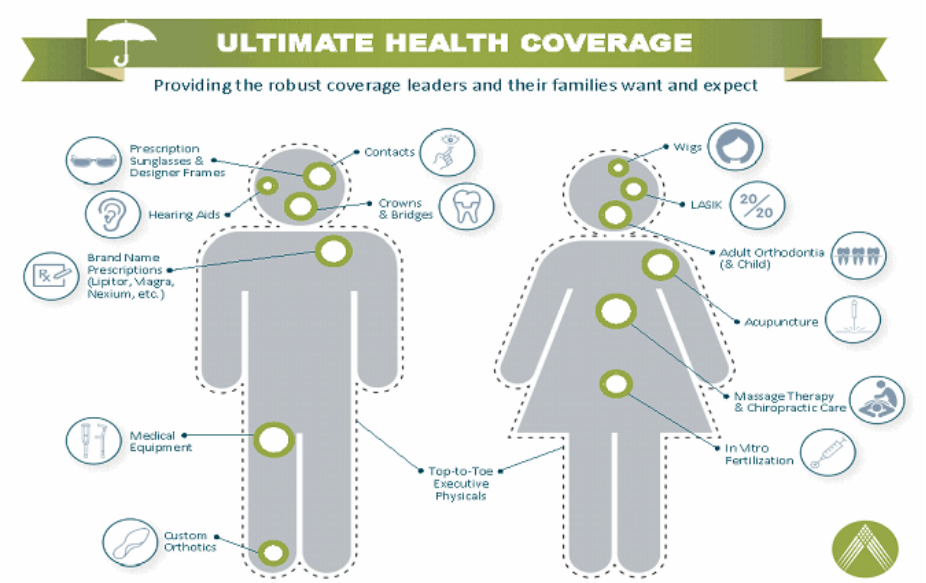
ArmadaCare®



The Ultimate Health Coverage plan is an innovative and convenient way to give an extra level of coverage for employees. It reimburses for many medical expenses not covered by the employer-sponsored base health plan. For more information contact Evie Bañaga at 800.449.4898 ext. 224.

Supplemental Medical Benefits	Samples of What is Eligible **(Not a Complete List)***	Platinum	Diamond	Diamond Plus (Requires 15+ to enroll)
Per-Occurrence (each injury, condition or illness) for medical out-of-pocket costs	Deductibles, co-pays, balance bills and other out-of-pocket costs for medically necessary services	$5,000	$10,000	$10,000
Other Supplemental Benefits		Per Covered Person per Year	Per Covered Person per Year	Per Covered Person per Year
Prescriptions	Co-pays, brand name and lifestyle prescriptions	$2,500	$3,000	$10,000
Mental Health	Counseling and substance abuse programs	$2,000	$3,000	$10,000
Medical Equipment	Durable medical equipment, wigs, hearing aids, orthotics	$2,000	$5,000	$10,000
Wellness Treatments	Acupuncture, massage therapy and chiropractic care (if not covered by primary plan)	$1,000	$1,500	$10,000
Executive Physicals	Comprehensive physicals for the primary member and enrolled spouse	$2,000 each	$2,500 each	$10,000 each
Ancillary Benefits		Per Covered Person per Year		
Dental Treatments	Routine care, child and adult orthodontia, crowns and bridges	$4,000	$5,000	$10,000
Vision Treatments	LASIK, contact lenses and prescription glasses & sunglasses	$1,000	$1,500	$10,000
Annual Family Maximum		$50,000	$100,000	$100,000

The levels are for each covered person, whether that person is the enrolled employee or his/her enrolled family member. All the reimbursed expenses across the benefit categories, including medical per occurrences, roll up to the overall annual family maximum, which is the same for a family of one or a family of six.

*These are examples of 213(d)- eligible expenses that are typically covered by the Ultimate Health plan. We cannot pre-certify specific medical treatments or procedures. A claim must be submitted for review before a claim will be accepted or denied for reimbursement.

TASC

Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions and vaccinations
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- You can choose to enroll in a Healthcare FSA, Dependent Care FSA, and more
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.
With less tax taken, your take-home pay increases!

Consider this example:
(For illustration only)

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA	With FSA
($600 spent using post-tax dollars)	($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of **$166 every month!**

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators/tasc-flexsystem-calculator/

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

PIAG Insurance has partnered with Aflac to offer an extensive voluntary benefits portfolio of a broad range of financial protection options with multiple ways to enroll. Employees may quote out personal lines for themselves and their family/friends, and employers may add coverage to cover their employees.

A Selection of Voluntary Personal Benefits through Aflac

Accident Insurance
(benefits for unexpected injuries)

- **Accident** - A guaranteed-issue, composite-rated, guaranteed-renewable accident product that offers several coverage levels to fit all budgets
- **Gunshot Wound** - A guaranteed-issue product that provides lump-sum benefits for injury due to non-fatal gunshot wounds

Disability Insurance
(income protection)

- **Disability** - A short-term disability product that replaces a portion of your income

Supplemental Health Insurance
(lump sum hospital confinement)

- **MedicalBridge** - A hospital confinement indemnity product that supplements your core medical coverage

Special Risk Insurance
(treatment & recovery from serious illness)

- **Cancer** - A cancer product that pays indemnity-based benefits to help cover medical and non-medical expenses related to a cancer diagnosis and treatment
- **Critical Illness** - A critical illness product that provides a lump-sum benefit for the diagnosis of a critical illness

Life Insurance
(family financial protection)

- **Universal Life** - A universal life product with flexibility that allows the employee to adapt to changing needs by varying amounts and premiums
- **Whole Life** - A permanent whole life insurance product that provides guaranteed level premiums, guaranteed cash values, and guaranteed death benefits as long as premiums are paid when due and no loans are taken

and more!

Contact us today to learn about all the ways we can help you plan for the unexpected.

www.piaginsurance.com | (770) 433-3050
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