Please review the New Employee Benefits packets For Health, Dental, and Vision.
These plans will start 4/1/2109

Each of you has a personalized Alpha & Omega Building Services Employee Enrollment Form
This will be used to either enrollment for benefits or waiving benefits.
Below is what must be done by all employees:

Section 1 Please review to confirm your information is correct

Section 2 This is where you will put Dependent information if you want them to be covered with you.
Dependents coverage is 100% you cost)

Section 3 Here you will select your benefits choice and who will be covered.
There are 2 Plan Groups.

Plan 1 A	United Health Care	Plan 2 A	Century HealthCare Limited Fixed Indemnity
Plan 1 B	United Health Care	Plan 2 B	Century HealthCare Limited Fixed Indemnity
Plan 1 C	Delta Dental of Ohio	Plan 2 C	Century HealthCare Dental
Plan 1 D	Eye Med Vision	Plan 2 D	Century HealthCare Dental

You will need to put you Plan choices in the appropriate box / boxes for all that you want covered.

Section 4 If and only if you take either United Health Care Medical (Plan 1 A or Plan 1 B) or either Century HealthCare Limited Fixed Indemnity (Plan 2 A or Plan 2 B) you need to will in your beneficiary information.

Section 5 If you do not want / need coverage put you initials in the boxes of the coverage you do not want and all that this may apply. **If you do not want any coverage from either Plan 1 or Plan 2 put Waive All Coverage**

Section 6 Here you need to Sign and date

This Enrollment and Payroll deduction form needs to be returned to me the day of your enrollment meeting, or Alpha & Omega Building Services Kettering office Human Resources.

Let me know if you questions.
My cell is the best way to reach me 513-602-6563.

Thanks

Robert L Cooney

Robert L. Cooney
EMPLOYEE BENEFITS PLUS
3386 Socialville Foster Rd.
Maineville, OH 45039
Office 513-459-2255
Cell 513-602-6563
Fax 866-593-4212
rlcooney1@gmail.com

UnitedHealthcare

Medical Rates for ALPHA & OMEGA BLDG SVCS INC

Effective Date: 4/01/2019 | Customer Number 009S9107

	Plan 1 A NEW	Plan 1 B NEW
Plan Name	**AN-EQ (Simple Choice HSA) Rx Plan: 459 - HSA**	**AX-PG (Premier PROformance) Rx Plan: IU**
Product	Choice HMO *	Choice + Insurance *
Check on Doctors & Hospitals	www.Welcometouhc.com	
	Click on Find Doctor (Don't select "Currently a Member"	
Pick your Network	Select Choice HMO (Network Plan)	Select Choice Plus (Network Plan)
	Click on Change Location (Put in your zip Code)	
	Select People or Places to verify who is in network	
HRA or HSA	HSA	No
Benefits*	**Network Single/Family**	**Network Single/Family**
Office Copay (PCP/SPC)	PCP Ded+80%, SPC Ded+80%	PCP $0 Kids/$15, SPC $50/$100
Hospital Copays	OP Ded+80%, IP Ded+80%	OP Ded+80%, IP Ded+80%
UC/ER/Major Diag Copay	UC Ded+80%, ER Ded+80%, MD Ded+80%	UC $25, ER $300 POD, MD Ded+80%
Other	ENRP, Lab/X-Ray Ded/Coins	ENRP, Lab/X-Ray Ded/Coins
Deductible	$5,000/$10,000 (Emb)	$3000/$6000 (Emb)
Coinsurance	80%	80%
Out-of-Pocket	$6,550/$13,100	$7150/$14300
Pharmacy	$10/50/100/250; 2.5x for M.O., Integrated med/rx ded	$15/40/75; 2.5x for M.O.
	Out of Network Single/Family	**Out of Network Single/Family**
Deductible	**No Benefits**	$7500/$15000 (Emb)
Coinsurance	**No Benefits**	50%
Out of Pocket	**No Benefits**	$15000/$30000
Enrollment		
	Rates (Billed)	**Rates (Billed)**
Rates	Weekly	Weekly
Employee	**$58.92**	**$78.51**
Employee + Spouse	**$188.55**	**$229.68**
Employee + Child(ren)	**$164.98**	**$202.20**
Employee + Family	**$294.61**	**$353.37**

High level benefit summary. Please see your plan summary for more detailed benefit description.

POD = Benefit paid as follows: Per Occurrence Deductible, then plan deductible and coinsurance.

LTD # = the number of services covered at that copay, after the limit plan deductible and coinsurance will apply, note PCP and SPC may be combined (see benefit summary)

Day x# = the max number of days the copay will apply

Delta Dental of Ohio
Dental Benefit Highlights for
Alpha & Omega Building Services #2459

DELTA DENTAL®

Delta Dental PPO℠ (Point-of-Service) *Coverage effective April 1, 2019*	**Delta Dental PPO Dentist** **Plan Pays**	**Delta Dental Premier® Dentist** **Plan Pays**	**Non-participating Dentist** **Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Brush Biopsy - to detect oral cancer	100%	80%	80%
Bitewing Radiographs – bitewing X-rays	100%	80%	80%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	60%	50%	50%
Sealants - to prevent decay of permanent teeth	60%	50%	50%
All Other Radiographs – other X-rays	60%	50%	50%
Minor Restorative Services - fillings and crown repair	60%	50%	50%
Endodontic Services - root canals	60%	50%	50%
Periodontic Services - to treat gum disease	60%	50%	50%
Oral Surgery Services - extractions and dental surgery	60%	50%	50%
Other Basic Services - misc. services	60%	50%	50%
Relines and Repairs - to bridges, dentures, and implants	60%	50%	50%
Major Services			
Major Restorative Services – crowns	40%	30%	30%
Prosthodontic Services - bridges, dentures, and implants	40%	30%	30%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	Up to age 19		

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.*

Maximum Payment – $1,000 per person total per calendar year on Basic Services, and Major Services. Diagnostic & Preventive services are excluded from the annual maximum. $500 per person total per lifetime on Orthodontics.

Deductible – $50 deductible per person total per calendar year on all services except diagnostic and preventive services, brush biopsy, bitewing X-rays, and orthodontic services.

Note – *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Ohio's largest dental benefits family!

As a member of Delta Dental of Ohio, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists – there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, we pay more than 90% of claims in 10 days or less. Delta Dental also offers world-class customer service from our BenchmarkPortal Certified Center of Excellence call center.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more – all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at (800) 524-0149 or look online at www.DeltaDentalOH.com.

PLAN 1 C	Weekly Rates
Employee only	$4.57
Employee with one depedent	$8.70
Employee with two or more depedents	$16.60

Plan 1 D
Alpha and Omega Building Services

Weekly Rates
Employee $1.61
Employee Plus 1 $3.06
Employee Plus Family $4.50

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $160 allowance, 20% off balance over $160	Up to $112
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Standard Progressive Lens	$80 Copay	Up to $50
Premium Progressive Lens[Δ]	$110 Copay - $200 Copay	Up to $50
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$200 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$40	N/A
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $85	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $160 allowance, 15% off balance over $160	Up to $160
Disposable	$0 copay, $160 allowance, plus balance over $160	Up to $160
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 24 months	

QL-0000074595

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

CENTURY HEALTHCARE

LIMITED FIXED INDEMNITY PLAN OPTION

Important Contacts

Century Healthcare
Customer Service and Claims
(877) 685-2432
Monday through Friday
7:00 AM – 7:00 PM CST

Member Web Portal
(Access important plan documents, claim forms & temporary ID cards)
www.centuryhealthcare.com
Username: CHC5942
Password: alpha

PHCS Limited Benefit Plan

PHCS Limited Benefit Network
www.multiplan.com/chc
(888) 371-7427

CERPASSRX®

Pharmaceutical Benefits
www.cerpassrx.com
Pharmacy Customer Service:
(844) 636-7506
Mail Order Number:
(844) 636-7506

Please Note: A separate claim form is needed for the AD&D, Accident Medical & Life benefits. You may access the claims form through the client web portal or call the Century Healthcare's Customer Service Department.

All benefits except Accident Medical, AD&D, and Term Life are subject to Benefit Year Maximums as shown above.
Benefit Year means the 12 consecutive months from the group's original effective date.
Please note that this is just a summary of the benefits and to know the full details of the policy the certificate of coverage needs to be reviewed once the policy is effective.
Benefits Effective 4/1/2019

Benefit Description	PLAN 2 A Value	PLAN 2 B Premier
Outpatient Physician Office Visit	Plan pays $50 per day (3 days)	Plan pays $70 per day (4 days)
Preventive Care	Plan pays $50 per day (1 day)	Plan pays $70 per day (1 day)
Well Child Visit	Plan pays $50 per day	Plan pays $70 per day
Outpatient Lab & X-Ray	Plan pays $65 per day (3 days)	Plan pays $75 per day (3 days)
Inpatient/Outpatient Surgery Benefits	N/A	Inpatient: Plan pays $2,000 Outpatient: Plan pays $2,000 (1 IP or 1 OP surgery)
Inpatient/Outpatient Anesthesia Benefits	N/A	Inpatient: Plan pays $500.00 Outpatient: Plan pays $500.00
Outpatient Minor Surgical Benefits	Plan pays $50 per day (1 day)	Plan pays $70 per day (1 day)
Hospital Confinement	Plan pays $150 per day (10 days)	Plan pays $300 per day (10 days)
Maternity	Included	Included
ICU Confinement Pays in lieu of the Hospital Confinement Benefit.	Plan pays $300 per day (3 days)	Plan pays $600 per day (3 days)
Substance Abuse Confinement	Plan pays $75 per day (3 days)	Plan pays $150 per day (3 days)
Mental Illness Disorder Confinement	Plan pays $75 per day (3 days)	Plan pays $150 per day (3 days)
Skilled Nursing Facility Confinement	Plan pays $75 per day (6 days)	Plan Pays $150 per day (6 days)
Accident Medical	Up to $5,000 per occurrence	Up to $5,000 per occurrence
Accidental Death & Dismemberment Employee Spouse Children	$15,000 $7,500 $3,000	$15,000 $7,500 $3,000
Term Life Employee	$10,000	$10,000
Pharmaceutical Benefits	Discount Rx	Copay Rx

Discount Rx Card
Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Receive instant savings of up to 85% based on all FDA approved drugs (brand & generic) at the pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 58,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies. Your discount may also apply to certain over-the-counter medications, diabetic supplies that have an NDC (National Drug Code), and even for certain pet medications that have human equivalent medications. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies.

Copay Rx Plan(s)
Tier 1 (Most Generics): $10 Co-Pay. Tier 2 (Some Generics & Preferred/Formulary Brand Name): $50 or 50%; whichever is greater. Tier 3 (Non-Preferred / Non-Formulary Brand Name): Employees pay 100% of the cost after pharmacy discounts. Mail order option available for 90 day prescription supply at $25 copay for tier 1 and $125 or 50% for tier 2 medications. Monthly Maximum of $200 Employee / $400 Family. No Deductible.

PHCS PPO Limited Benefit Network
All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.

Employee Cost per Paycheck	PLAN 2 A Value	PLAN 2 B Premier
❒ Employee Only	$7.52	$18.78
❒ Employee + Spouse	$21.05	$46.53
❒ Employee + Child(ren)	$15.94	$36.12
❒ Employee + Family	$28.05	$62.70

CENTURY HEALTHCARE

Plan 2 C

SILVER DENTAL PLAN

SILVER DENTAL PLAN

$1,000 / Plan Year Maximum

Type 1: Preventive & Diagnostic

a.	Oral exams, including prophylaxis	$36.00
b.	Bitewings, per film	$4.80
c.	X-ray, panoramic or cephalometric	$36.00
d.	Sealants / topical fluoride	$10.20
e.	Space maintainers	$108.00

Type 2: Major Restorative

a.	Crowns, bridges & dentures	$180.00
b.	Pre-fabricated crowns	$60.00
c.	Crown build-up procedures	$48.00

Type 3: Minor Restorative

a.	Fillings	$42.00
b.	Crown, bridge, and denture repairs	$24.00
c.	Relining or rebasing dentures	$60.00

Type 4: Endodontics

a.	Root Canals, apicoectomies	$192.00
b.	Root amputation	$96.00
c.	Therapeuticpulpotomy, retrograde fillings, apexification, and hemisection	$48.00

Type 5: Periodontics (Lifetime Maximum of $500)

a.	Tissue grafts or bone surgery	$96.00
b.	Gingivectomy (per quadrant), periodontal scaling, periodontal splinting, root planning	$60.00
c.	Gingival curettage (per quadrant)	$36.00
d.	Gingivectomy (per tooth)	$24.00

Type 6: Oral Surgery

a.	Surgeries Level 1 (ex. Removal of exostosis)	$120.00
b.	Surgeries Level 2 (ex. Removal of impacted tooth)	$66.00
c.	Surgeries Level 3 (ex. Simple extraction)	$36.00

Type 7: General Anesthesia and IV

a.	IV, first half Hr. general, each additional ¼ Hr.	$72.00

Type 8: Orthodontia $500.00

Types 1 through 7 are subject to an annual maximum of $1,000.00. Types 2, 5, 6a, 7, and 8 are subject to a 12 month waiting period

Careington Dental PPO Network

To access the Careington Dental PPO provider directory visit: www.careington.com/co/centuryPPO

Please note that this is not an insured product. It is a discount program offering services through participating providers.

Davis Vision Discount Program Plus Eye Exam[1]

Eye Examination - Once every 12 months
Eye Examination - $10 copay
Frames (retail price) - 35% off provider's usual & customary (U&C)
Single Vision lenses[2] - Member pays $45
Bifocal lenses[2] - Member pays $65
Trifocal lenses[2] - Member pays $95
Lenticular lenses[2]- Member pays $120

Value-Added Features

Non-prescription Sunglasses - 20% off provider's U&C
Other Ancillary Products/Solutions - 20% off provider's U&C
Additional Pairs - 30% off provider's U&C for complete pairs on same transaction; otherwise 20% off providers U&C
Retinal Imaging – Member pays $39

Contact Lens Benefits (in lieu of eye glasses)

Contact Lens Evaluation, Fitting, & Follow-Up Care - 15% off provider's U&C
Contact Lenses - 15% off provider's U&C

Out-of-Network Benefits:

Eye Examination - $40 reimbursement
Visit www.davisvision.com to find a provider.

Additional Lens Options[2]

Tinting of Plastic Lenses (Solid / Gradient) – Member pays $15
Scratch-Resistant Coating - Member pays $15
Polycarbonate Lenses – Member pays $35
Ultraviolet Coating – Member pays $15
Anti-Reflective (AR) Coating (Standard) - Member pays $45
Anti-Reflective (AR) Coating (Premium/Ultra) – 20% off provider's U&C
Progressive Lenses (Standard) (add on to Bifocal lens) - Member pays $65
Progressive Lenses (Premium/Ultra) (add on to Bifocal lens) – 20% off provider's U&C
High-Index Lenses - Member pays $65
Polarized Lenses Member pays $75
Plastic Photochromic Lenses – Member pays $75

WEEKLY COST

Employee Only	$2.55
Employee + Spouse	$4.46
Employee + Child(ren)	$5.88
Employee + Family	$7.78

[1] Additional discounts are not applicable at Costco, Sam's Club, and Walmart locations, or where limited by law or manufacturer restrictions.
[2] Special lens designs, materials, powers, and frames may require additional cost.
Minimum participation required to issue policy: 2 enrolled lives

Plan 2 D

CENTURY HEALTHCARE

DAVIS VISION DESIGNER PLAN

BENEFIT DESCRIPTION	FREQUENCY
Eye Examination	12 Months
Spectacle Lenses	12 Months
Frame	24 Months
Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months

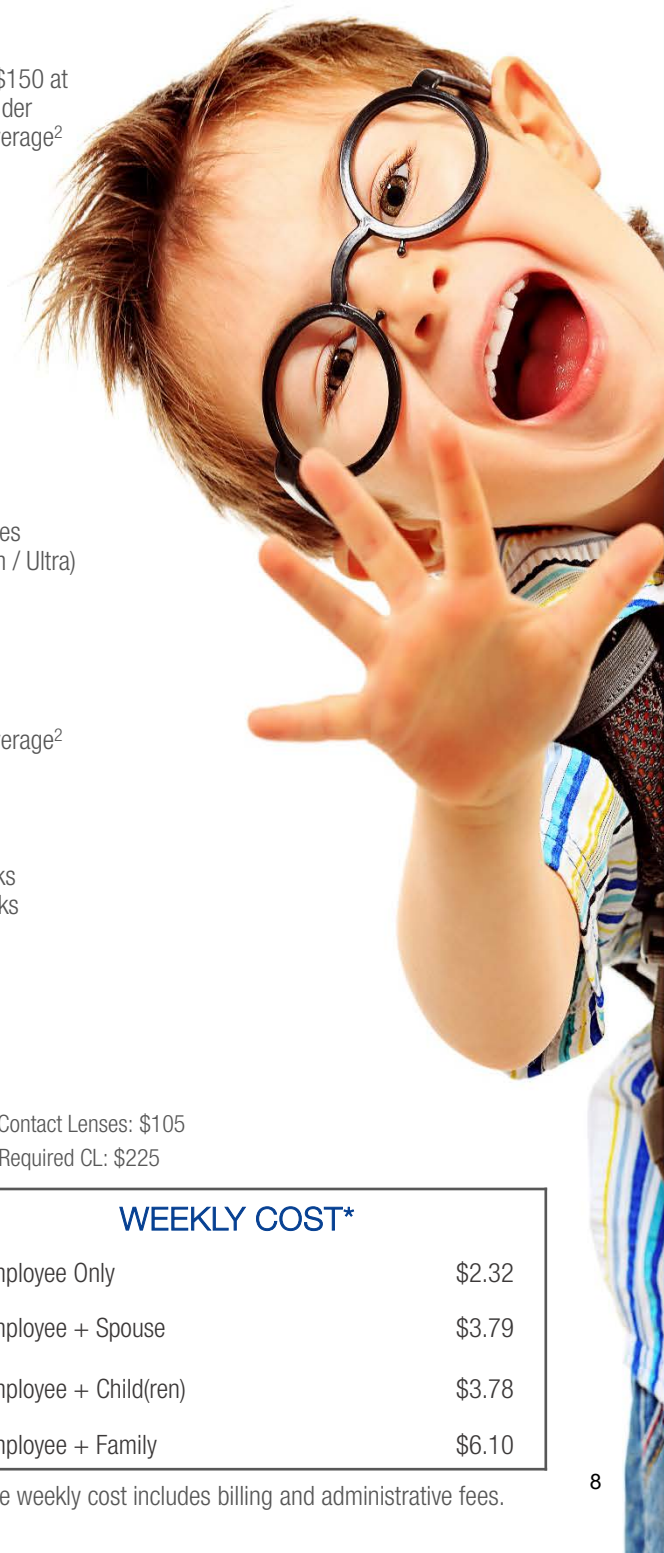
COPAYMENTS	
Eye Examination	$10
Spectacle Lenses	$15
Contact Lens Evaluation, Fitting & Follow-Up Care	$0[1]

EYEGLASS BENEFIT

Frame Allowance (Retail):	Up to $200 at Vision Works or $150 at any other participating provider Plus a 20% discount on any overage[2]
Davis Vision Frame Collection[3] (in lieu of Allowance):	
Fashion level	Covered
Designer level	Covered
Premier level	Covered
Clear plastic single-vision, lined bifocal, trifocal or lenticular	Covered
Tinting of Plastic Lenses	Covered
Scratch-Resistant Coating	Covered
Polycarbonate Lenses (Children[4] / Adults)	$0 / $30
Ultraviolet Coating	$12
Anti-Reflective (AR) Coating (Standard / Premium / Ultra)	$35 / $48 / $60
High-Index Lenses	High-Index Lenses
Polarized Lenses	Polarized Lenses
Plastic Photochromic Lenses	Plastic Photochromic Lenses
Progressive Lenses (Standard / Premium / Ultra)	Progressive (Standard / Premium / Ultra)
Scratch Protection Plan: Single Vision / Multifocal Lenses	$20 / $40
One-year eyeglass breakage warranty	Covered

CONTACT LENS BENEFIT (IN LIEU OF EYEGLASSES)

Contact Lens: Materials Allowance	Up to $150 Plus a 15% discount on any overage[2]
Evaluation, Fitting & Follow-Up Care – Standard & Specialty Lens Types	15% Discount[2]
Collection Contact Lenses[3] (in lieu of Allowance):	
Disposable	Up to 8 boxes / multi-packs
Planned Replacement	Up to 4 boxes / multi-packs
Evaluation, Fitting & Follow-up Care	Covered
Visually Required Contact Lenses (with prior approval)	
Materials, Evaluation, Fitting & Follow-Up Care	Covered



Out-of-Network Reimbursement

Eye Examination: $50	Single Vision Lenses: $50	Trifocal Lenses: $100	Elective Contact Lenses: $105
Frame: $70	Bifocal/Progressive Lenses: $75	Lenticular Lenses: $100	Visually Required CL: $225

Visit www.davisvision.com to find a provider.

[1] Copayment applies to Collection Contact Lenses only.
[2] Additional discounts not applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions.
[3] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.
[4] Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.

WEEKLY COST*

Employee Only	$2.32
Employee + Spouse	$3.79
Employee + Child(ren)	$3.78
Employee + Family	$6.10

* The weekly cost includes billing and administrative fees.