Columbus 1059 Proposal - 7/15/2022 (4th Proposal)	Plan Design Changes: Effective 1/1/2024					
	Plan A		Plan B			
EMPLOYEE ELIGIBILITY						
36+ hours : Employee + Spouse Eligibility						
Hours Required	36 hours per week to qualify and maintain benefits		36 hours per week to qualify and maintain benefits			
Years of Service	3 or more years of service		N/A			
Initial Waiting Period	N/A		1 Year			
Family Coverage	**Spouse and Child**		**Spouse and Child**			
30 to 35.99 hours : Employee + Child(ren) Eligibility						
Hire Date	N/A		Before or after ratification			
Hours Required	N/A		30 hours per week to qualify and maintain benefits			
Years of Service	N/A		N/A			
Initial Waiting Period	N/A		1 Year			
Family Coverage	N/A		**Dependent Child(ren) Only**			
27 to 29.99 hours : Employee Only Eligibility						
Hire Date	N/A		Before or after ratification			
Hours Required	N/A		27 hours per week to qualify and maintain benefits			
Years of Service	N/A		N/A			
Initial Waiting Period	N/A		1 Year			
Family Coverage	N/A		**N/A**			
Ancillary Eligibility						
Hire Date	N/A		Before or after ratification			
Hours Required	N/A		20 hours per week to qualify and maintain benefits			
Years of Service	N/A		N/A			
Initial Waiting Period	N/A		1 Year			
Family Coverage	Spouses of FT associates can enroll in ancillary plan		Spouses of FT associates can enroll in ancillary plan			
CALENDAR YEAR 2023	With health screening	Without Health Screening	With health screening	Without Health Screening		
Employee	$23.50	$30.55	$18.50	$24.05	$1.00	$1.00
Employee + Spouse	$32.00	$41.60	$27.00	$35.10	$2.00	$2.00
Employee + Child(ren)	$29.50	$38.35	$24.50	$31.85	$2.00	$2.00
Employee + Family	$35.50	$46.15	$30.50	$39.65	$3.00	$3.00
Ancillary Only	$3.00		$3.00			
Monthly Spousal Surcharge (All Spouses)	$250.00		$250.00			
CALENDAR YEAR 2024	With health screening	Without Health Screening	With health screening	Without Health Screening		
Employee	$24.50	$34.30	$19.50	$27.30	$1.00	$1.00
Employee + Spouse	$34.00	$47.60	$29.00	$40.60	$2.00	$2.00
Employee + Child(ren)	$31.50	$44.10	$26.50	$37.10	$2.00	$2.00
Employee + Family	$38.50	$53.90	$33.50	$46.90	$3.00	$3.00
Ancillary Only	$3.00		$3.00			
Monthly Spousal Surcharge (All Spouses)	$250.00		$250.00			
CALENDAR YEAR 2025	With health screening	Without Health Screening	With health screening	Without Health Screening		
Employee	$25.50	$35.70	$20.50	$28.70	$1.00	$1.00
Employee + Spouse	$36.00	$50.40	$31.00	$43.40	$2.00	$2.00
Employee + Child(ren)	$33.50	$46.90	$28.50	$39.90	$2.00	$2.00
Employee + Family	$41.50	$58.10	$36.50	$51.10	$3.00	$3.00
Ancillary Only	$4.00		$4.00			
Monthly Spousal Surcharge (All Spouses)	$250.00		$250.00			
MEDICAL BENEFITS	In Network	Out of Network	In Network	Out of Network		
Medical Plan Essentials						
Preventive Coverage	100%	50%	100%	50%		
Predominant Co-Insurance (Plan share)	80%	50%	70%	50%		
Predominant Co-Insurance (Associate share)	20%	50%	30%	50%		
COE Coinsurance (Plan Share)	95%	N/A	95%	N/A		
COE Coinsurance (Associate Share)	5%	N/A	5%	N/A		
	100% of travel for 2 covered, deductible waived		100% of travel for 2 covered, deductible waived			
Annual Deductible: Single / Family	$750 / $1,500	$1,500 / $3,000	$1,250 / $2,500	$2,500 / $5,000		
Out of Pocket Max: Single/Family	$4,000 / $8,000	$8,000 / $16,000	$6,250 / $12,500	$12,500 / $25,000		
2024 Out of Pocket Max: Single/Family	$4,500 / $9,000	$9,000 / $18,000	$6,500 / $13,000	$12,000 / $24,000		
2025 Out of Pocket Max: Single/Family	$5,000 / $10,000	$10,000 / $20,000	$6,500 / $13,000	$12,000 / $24,000		
Rx Costs Count Towards Medical Maximums	No		No			
Point Of Service Coinsurance (Do not apply to deductibles)						
Copays apply to Deductible	No	No	No	No		
Primary Care Office Visit Coinsurance	$25	50% after deductible	$25	50% after deductible		
Specialist Office Visit Coinsurance	$40	50% after deductible	$40	50% after deductible		
Urgent Care	$50	50% after deductible	$50	50% after deductible		
Telemedicine visit	$25	50% after deductible	$25	50% after deductible		
Anthem LHO (or carrier equivalent)	$10	N/A	$10	N/A		
Emergency Room Copay	$175 + 20% coinsurance		$175 + 30% coinsurance			
Emergency Room Copay (Waived if Admitted)	Yes (Only copay is waived, not coinsurance)		Yes (Only copay is waived, not coinsurance)			
PHARMACY/PRESCRIPTION DRUG BENEFITS						
RX OOP MAX	$5,000 / $10,000		$5,000 / $10,000			
Retail 30 Days	Min	Max	Min	Max		
Retail Generic Copay	Greater of 10% or $10.00	$25.00	Greater of 10% or $10.00	$25.00		
Retail Brand Formulary Copay	Greater of 20% or $20.00	$75.00	Greater of 20% or $20.00	$75.00		
Retail Brand Non Formulary	Greater of 30% or $40.00	$100.00	Greater of 30% or $40.00	$100.00		
Specialty - Generic Copay	8%	$100.00	8%	$100.00		
Specialty - Formulary Copay	15%	$150.00	15%	$150.00		
Specialty - Non Formulary Copay	25%	$175.00	25%	$175.00		
Mail-Order 90 Days	Min	Max	Min	Max		
Mail-Order Generic Copay	Greater of 10% or $25.00	$62.50	Greater of 10% or $25.00	$62.50		
Mail-Order Brand Formulary	Greater of 20% or $50.00	$187.50	Greater of 20% or $50.00	$187.50		
Mail Order Brand Non Formulary	Greater of 30% or $100.00	$250.00	Greater of 30% or $100.00	$250.00		
Retail 90 Days	Min	Max	Min	Max		
Retail Generic Copay	Greater of 10% or $27.50	$68.75	Greater of 10% or $27.50	$68.75		
Retail Brand Formulary Copay	Greater of 20% or $55.00	$206.25	Greater of 20% or $55.00	$206.25		
Retail Brand Non Formulary	Greater of 30% or $110.00	$275.00	Greater of 30% or $110.00	$275.00		
DENTAL	In Network	Out of Network	In Network	Out of Network		
Spouse and Dependent Coverage Available	Yes		Yes			
Annual Deductible ***(Applies to both networks)***	$100		$100			
Preventive Coinsurance	100%	80%	100%	80%		
Basic Coinsurance	80%	50%	80%	50%		
Major Coinsurance	80%	50%	80%	50%		
Annual Maximum Benefit	$2,000		$2,000			
Orthodontia Coverage	Yes	Yes	Yes	Yes		
Orthodontia Coinsurance	50%	50%	50%	50%		
Orthodontia Lifetime Maximum Benefit	$2,000	$2,000	$2,000	$2,000		
VISION	In Network	Out of Network	In Network	Out of Network		
Spouse and Dependent Coverage Available	Yes		Yes			
Exams	$0 Copay One/Year	$30 Copay One/Year	$0 Copay One/Year	$30 Copay One/Year		
Frames	$150 annual max	$25 annual max	$150 annual max	$25 annual max		
Lenses	No charge; limit 1 set per year	$80 annual max (Varies by type)	No charge; limit 1 set per year	$80 annual max (Varies by type)		
Contact Lenses	$150 Max every year in lieu of lenses	N/A	$150 Max every year in lieu of lenses	N/A		
INCOME REPLACEMENT[8]						
Life Benefit						
--Employee	36+ hours per week: $25,000 / Under 36 hours per week: $10,000		36+ hours per week: $25,000 / Under 36 hours per week: $10,000			
-- Enrolled Spouse	$5,000.00		$5,000.00			
-- Enrolled Child	$2,500.00		$2,500.00			
Accidental Death & Dismemberment						
--Employee	36+ Hours: $25,000 / Under 36 Hours: $10,000		36+ Hours: $25,000 / Under 36 Hours: $10,000			
Short Term Disability						
--Replacement Rate	66 2/3% of Salary		66 2/3% of Salary			
--Maximum Benefit Period	26 Weeks		26 Weeks			
--Elimination Period	7 days		7 days			
--Maximum Benefit (Weekly)	36+ Hours: $300 Less than 36 Hours: $150		36+ Hours: $300 Less than 36 Hours: $150			
FUNDING AND RESERVES						
Policy	Pass-through with guardrail language					