



# 2018 EMPLOYEE BENEFITS SUMMARY

Full-time eligible team members start coverage after 60 days of employment. Some benefits are provided free of charge by the company, others are optional and must be elected by the employee and are paid through payroll deduction. Many benefit premiums are deducted on a pre-tax basis.

## Medical

Four plans from which to choose  
Administered by Wellmark Blue Cross Blue  
Shield Worldwide networks

## Dental

Two plans from which to choose  
Administered by Delta Dental of Iowa  
Delta Premier or Delta PPO networks

## Vision

Annual allowance for routine exam  
Annual allowance toward purchase of glasses  
or contacts

## Pre-tax Savings Plans

Health Savings Account (HSA)  
Health Care Flexible Spending Account (FSA)  
Dependent Care Flexible Spending Account (FSA)

## Paid Time Off

Paid holidays  
Vacation  
Additional programs based on job category

## Short-term Disability (STD)

Company paid core benefit  
Optional supplemental buy-up coverage

## Long-term Disability (LTD)

Company paid core benefit  
Optional supplemental buy-up coverage

## Life Insurance

Company paid benefit including AD&D  
Optional supplemental buy-up coverage  
Optional spouse and dependent coverage

## Other Benefits

Wellness and tuition reimbursements  
Employee assistance program  
Will preparation service  
Employee discounts  
Referral bonus  
Travel Assistance

## 401(k) Retirement Plan

Participation after 60 days of service  
Automatic enrollment with annual step-up  
Company matches 50 percent of your deferral (up  
to 6 percent) after one year of service  
May change your deferral, investments or opt  
out any time

## Medical Plan Options

All plans administered by Wellmark Blue Cross Blue Shield and utilize worldwide network.

	Light		Basic		Choice Savings		Premier	
<b>Preventative Care</b>	100% in-network		100% in-network		100% in-network		100% in-network	
<b>Office Visit</b>	\$20 co-pay		\$30 after deductible		\$0 after deductible		\$25 co-pay	
<b>Deductible</b>	\$5,000 Single	\$10,000 Family	\$3,000 Single	\$6,000 Family	\$2,500 Single	\$5,000 Family	\$0 Single	\$0 Family
<b>Co-Insurance</b>	50% after deductible		20% after deductible		0% after deductible		10%	
<b>Out-of-Pocket Maximum (OPM)</b>	\$6,850 Single	\$13,700 Family	\$4,500 Single	\$9,000 Family	\$2,500 Single	\$5,000 Family	\$2,000 Single	\$4,000 Family
<b>Monthly Premium</b> <i>Single/Member+1/Family</i>	Tobacco: \$36 / \$70 / \$98 Non-Tobacco: \$0 / \$35 / \$60		Tobacco: \$92 / \$160 / \$195 Non-Tobacco: \$47 / \$88 / \$122		Tobacco: \$195 / \$357 / \$490 Non-Tobacco: \$120 / \$253 / \$359		Tobacco: \$340 / \$640 / \$865 Non-Tobacco: \$270 / \$565 / \$798	

- 1) Use of non-network providers will reduce your benefit(s) and increase your deductible and/or out-of-pocket maximum.
- 2) Both the Basic and Choice Savings plans are high deductible plans; you pay 100% of claims, except preventive and well-baby care, until the deductible is met.
- 3) Preventive Care guidelines state a preventive exam/procedure that becomes diagnostic must apply to the deductible.
- 4) Non-tobacco discounts must be re-elected each year.
- 5) A working spouse who has other coverage available through their own employer will not be eligible to enroll in an Ruan medical plan. Refer to Working Spouse Exclusion in the Employee Benefits Guide.
- 6) Under Choice Savings, Two Person or Family elections share the higher family deductible and out-of-pocket maximums.

## Prescription Drug

All medical plans include prescription drug coverage.

	Light	Basic-Preventive	Basic-All others	Choice Savings-Preventive	Choice Savings-All others	Premier
<b>Tier 1-Generic</b>	\$15 or 25% <i>(whichever is greater)</i>	\$20 or 25% <i>(whichever is greater)</i>	\$20 or 25% <i>(whichever is greater after deductible)</i>	\$15 or 25% <i>(whichever is greater)</i>	\$0 <i>(after deductible)</i>	\$10 or 25% <i>(whichever is greater)</i>
<b>Tier 2-Select Brands</b>	50% <i>(after deductible)</i>	\$35 or 25% <i>(whichever is greater)</i>	\$35 or 25% <i>(whichever is greater after deductible)</i>	\$35 or 25% <i>(whichever is greater)</i>	\$0 <i>(after deductible)</i>	20%
<b>Tier 3- All Other Brands</b>	50% <i>(after deductible)</i>	\$50 or 25% <i>(whichever is greater)</i>	\$50 or 25% <i>(whichever is greater after deductible)</i>	\$45 or 25% <i>(whichever is greater)</i>	\$0 <i>(after deductible)</i>	20%
<b>Specialty Drugs</b>	50% <i>(after deductible)</i>	20% <i>(after deductible)</i>		\$85 co-pay <i>(after deductible)</i>		10% co-insurance

- 1) Out-of-Network benefits equal your co-pay or 50%, whichever is greater, and is subject to Usual Customary & Reasonable charges (UCR).
- 2) Under the Light, Basic and Choice Savings plans, the deductible is waived for preventive medication. To see if a medication is labeled as preventive visit [www.wellmark.com](http://www.wellmark.com), click Wellmark Drug List, then select Blue Rx Formulary under Printable Drug Lists.
- 3) There is a mail order program available for high cost maintenance drugs. For three co-pays you receive a 90 day supply without the "whichever is greater" clause, allowing additional savings.
- 4) Some specialty drugs or self-administered injectables will require a written prescription to be filled at a retail or Caremark Specialty pharmacy to be covered.

## Dental

Plans administered by Delta Dental of Iowa and offer Delta Premier or Delta PPO networks.

	Standard Dental		Premier Dental	
	Premier Network	PPO Network	Premier Network	PPO Network
<b>Preventative Care</b>	20% co-insurance		0% co-insurance	
<b>Annual Deductible</b>	\$50	\$25	\$25	\$15
<b>Basic Care</b>	20% <i>(after deductible)</i>	10% <i>(after deductible)</i>	20% <i>(after deductible)</i>	10% <i>(after deductible)</i>
<b>Major Care</b>	50% <i>(after deductible)</i>		50% <i>(after deductible)</i>	
<b>Dental Maximum</b>	\$1,000/year/person		\$2,000/year/person	
<b>Orthodontia</b> <i>(children age 19 and younger only)</i>	\$50 ortho. deductible 50% Lifetime max: \$1,000		\$50 ortho. deductible 50% Lifetime max: \$1,500	
<b>Monthly Premium</b> <i>Single/Member+1/Family</i>	\$4.49 / \$9.70 / \$15.92		\$19.00 / \$39.50 / \$74.11	

\*Out-of-Network rates are subject to Usual Customary & Reasonable charges (UCR).

## Vision

Plans administered by VSP and utilize the VSP Signature network.

	Plan Allowance
<b>Annual Exam</b>	\$40
<b>Glasses or Contacts</b> <i>(one or the other, once per year)</i>	\$125
<b>Monthly Premium</b> <i>Single/Member+1/Family</i>	\$6.09 / \$12.71 / \$19.91

- 1) Network providers offer discounts up to a 20% on goods and services.
- 2) Members are responsible for charges over the annual plan allowances.

**Note:** This handout is for informational purposes only. If there are any discrepancies between this brochure and the plan document, the plan document will govern. For more information, please consult the Employee Benefits Guide, Summary Plan Description or Employee Policy Manual.

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Additional details are available at [www.ruan.com/benefits](http://www.ruan.com/benefits) or on the Hub

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