BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

HEALTH PLAN COMPARISON

	CORE PPO PLAN				HEALTH INVESTMENT PLAN				PREMIER PPO PLAN			
Weekly Premiums	EMP	EMP/SP	EMP/CH	EMP/SP/CH	EMP	EMP/SP	EMP/CH	EMP/SP/CH	EMP	EMP/SP	EMP/CH	EMP/SP/CH
Medical/Prescription	$0.00	$20.77	$13.67	$25.75	$17.28	$41.17	$27.09	$51.05	$34.93	$79.53	$60.59	$105.24
Deductible	**In-Network**				**In-Network**				**In-Network**			
Individual	$4,000				$2,000				$1,000			
2 Individuals	$8,000				$3,400				$2,000			
3+ Individuals	$8,000				$4,000				$2,000			
Out-of-Pocket Max (includes deductible)												
Individual	$7,000				$4,000				$4,000			
2 Individuals	$14,000				$7,000				$8,000			
3+ Individuals	$14,000				$8,000				$8,000			
Office Visits & Specialist												
Preventive-Care Visit	Covered 100%				Covered 100%				Covered 100%			
PCP Office Visit	$40 copay				80% after deductible				$25 copay			
Specialist Office Visit	$60 copay				80% after deductible				$40 copay			
Physical/Speech/ ABA Therapy	70% after deductible				80% after deductible				80% after deductible			
Emergency & Hospitalization												
Inpatient Hospital	70% after deductible				80% after deductible				80% after deductible			
Emergency Room	70% after deductible				80% after deductible				80% after deductible			
Urgent Care	$75 copay				80% after deductible				$50 copay			
Prescriptions												
Preventive Medications (Blood Pressure and Cholesterol Lowering)	Subject to copay below				Covered 100%				Subject to copay below			
Generic	$10 copay				$10 copay after deductible				$10 copay			
Preferred	30% - $25/$75				30% - $25/$75 after deductible				30% - $25/$75			
Non-Preferred	50% - $50/$100				50% - $50/$100 after deductible				50% - $50/$100			
Specialty Medications	50% to $250 copay				50% to $250 copay after deductible				50% to $250 copay			

Gordon® FOOD SERVICE

BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

HEALTH PLAN WEEKLY PREMIUMS

Weekly Insurance Premiums

	EMP	EMP/SP	EMP/CH	EMP/SP/CH(REN)
CORE PPO PLAN *Medical/Prescription*	$0.00	$20.77	$13.67	$25.75
HEALTH INVESTMENT PLAN *Medical/Prescription*	$17.28	$41.17	$27.09	$51.05
PREMIER PPO PLAN *Medical/Prescription*	$34.93	$79.53	$60.59	$105.24
DENTAL	$2.26	$4.77	$4.31	$6.80
VISION	$1.13	$2.25	$2.14	$3.31

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BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

PRE-TAX SAVINGS ACCOUNTS

HEALTH PLAN	PREMIER PPO CORE PPO	HEALTH INVESTMENT PLAN (HIP)	
ACCOUNT TYPE	**FSA**	**LIMITED PURPOSE FSA**	**HSA**
Contribution	$3,200	$3,200	S - $4,150 F - $8,300
Eligible Expenses	Medical	Dental	Medical
	Prescription	Vision	Prescription
	Dental		Dental
	Vision		Vision

HEALTH INVESTMENT PLAN (HIP)			
HSA	**IRS Limit**	**Company Contribution**	**EMPLOYEE CONTRIBUTION MAXIMUM**
1 Individual	$4,150	$500	$3,650
2 Individuals	$8,300	$750	$7,550
3+ Individuals	$8,300	$1,000	$7,300
Age 55+	Additional $1,000 catch-up contributions allowed		

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Gordon® FOOD SERVICE

BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

DENTAL & ORTHODONTIA PLAN

DELTA DENTAL®

The Gordon Food Service Dental Plan is administered by Delta Dental of Michigan. This Plan is purchased separately from the medical coverage. To locate an in-network dentist, visit www.deltadentalmi.com and click on "Find a Dentist".

Dental Coverage

ANNUAL DENTAL MAXIMUM
$1,700 all dental services

PREVENTIVE DENTAL SERVICES
- 100% coverage
- Cleanings/exams and bitewing x-rays
- Twice per year

ANNUAL DEDUCTIBLE (Minor & Major Restorative Procedures)
$25 per person per year

MINOR RESTORATIVE DENTAL PROCEDURES
- 20% Co-Insurance (Plan covers 80%)
- Fillings, crowns, root canals, extractions, etc.

MAJOR RESTORATIVE DENTAL PROCEDURES
50% Co-Insurance (Plan covers 50%) Bridges, dentures, etc.

EMP	EMP/SP	EMP/CH	EMP/SP/CH
$2.26	$4.77	$4.31	$6.80

Orthodontic Coverage

ORTHODONTIA MAXIMUM
$1,500 per course of treatment

COURSE OF TREATMENT
24 month lapse between services for new treatment to be payable (benefit renews)

COVERAGE DETAILS
- Services covered at 50%
- Includes initial banding and periodic visits
- No age limit

DELTA DENTAL ID CARDS PROVIDED BUT NOT REQUIRED TO ACCESS COVERAGE

When you seek services from an in-network Delta Dental provider, they can verify coverage with the following information:
- Employee Social Security Number
- Plan 1800
- (800) 524-0149

Benefits of Using In-network Dentists

To maximize the benefits available under the plan, Gordon Food Service has partnered with Delta Dental of Michigan to offer services for a reduced fee if an in-network dentist is used. The dental network consists of Delta Dental PPO and the Delta Dental Premier networks. Dentists outside the network may be used with the same dental benefit coverage; however, you will not receive a reduced rate for those services and may be billed for services over what the plan covers.

Gordon® FOOD SERVICE

BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

AETNA VOLUNTARY PLANS

Aetna Voluntary plans can help offset out-of-pocket medical or household expenses. Receive direct cash payments to help pay copays or deductibles. Or use the cash payment for everyday expenses. Review plan details for the Accident, Critical Illness and Hospital plans to decide if any are right for you.

ACCIDENT PLAN	CRITICAL ILLNESS PLAN	HOSPITAL INDEMNITY PLAN
The Accident Plan pays cash benefits directly to you for a covered accident. Benefits payable for accidental injuries include initial and follow-up treatment; ambulance trips for concussions, dislocations, fractures, burns and more.	The Critical Illness Plan provides peace of mind for the unexpected. This plan pays cash benefits to you when you are diagnosed with a covered condition such as heart attack, stroke, or major organ failure. As an added bonus, you can also receive $100 just for having an annual routine physical with your doctor.	The Hospital Indemnity Plan pays cash benefits to you for a covered inpatient hospital stay. This provides payouts for hospital admission, daily stays and ICU care.

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Gordon® FOOD SERVICE

BENEFITS, HEALTH + WELLNESS

2024 BENEFITS

VISION PLAN

The Vision Plan is administered by EyeMed. To locate a provider near you, visit **eyemedvisioncare.com**.
This plan is purchased separately from the medical coverage.

	MEMBER COST	REIMBURSEMENT
Annual Exam	**In-Network**	**Out-of-Network**
	Covered 100%	Covered 100%
Contact Lens Fit		
Standard	Up to $40	N/A
Premium	10% off retail price	N/A
Frames		
	$150 allowance 80% off balance over $150	Up to $80
Standard Plastic Lenses		
Single Vision	$15	Up to $70
Bifocal	$15	Up to $80
Trifocal	$15	Up to $90
Standard Progressive Lens	$50	Up to $80
Premium Progressive Lens	$50	Up to $80
	$120 allowance is combined for standard and contact lenses	
Contact Lenses		
Conventional	$120 allowance 15% off balance over $120	Up to $120
Disposables	$120 allowance	Up to $120
	$120 allowance is combined for standard and contact lenses	
Frequency		
Exam	Once every calendar year	
Frames	Once every calendar year	
Standard Plastic Lenses OR Contact Lenses	Once every calendar year	

EMP	EMP/SP	EMP/CH	EMP/SP/CH
$1.13	$2.25	$2.14	$3.31

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