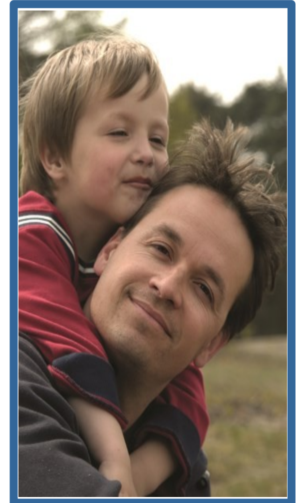
REPUBLIC PLASTICS, Ltd.

# 2020-2021 Employee Benefit Guide

# 2020-2021 Benefits Booklet

**"Working Together for Healthy Well-Being and Financial Security"**

*Announcing…*



# 2020-2021 Benefit Options

Republic Plastics is pleased to provide you with a benefit program designed to help safeguard your financial and health care needs.

This booklet will assist you in making your benefit decisions. It's not intended as a complete description of provisions of the benefit plans, but as a guide to help you in making the benefit choices that are best for you. Complete copies of the individual plan summaries and booklets are available by contacting Human Resources.

**You may contact Laurie Magnon, Human Resources with questions at 830-557-5574 or via email at lmagnon@republicplastics.com.**

# Introduction

## Who is Eligible?

- A full-time employee working 30 hours or more per week.

Coverage is scheduled to begin on the first of the month following 30 days from your date of hire.

## Who are My Eligible Dependents?

For medical you may cover your lawful spouse and dependent children. To be eligible, a child must be less than 26 years of age, regardless of student status. Stepchildren who reside with you and are primarily dependent upon you for support are also eligible subject to these same age limits. A child who is physically or mentally handicapped may be eligible for coverage at any age.

For Supplemental Life coverage you may cover your lawful spouse and dependent children. A dependent child is defined as a natural child, adopted child or stepchild who is under age 26 and unmarried.

## What Happens if I Fail to Enroll?

Newly eligible employees, who do not enroll by the deadline given to them, will be enrolled for only Basic Life/AD&D Insurance.

If you do not wish to enroll for Medial benefits, you must complete an application to decline coverage .

## Can I Change My Coverage During the Year?

The benefits you choose will remain in effect through the end of the plan year. You can only make a change to your coverage:

- During open enrollment, or
- During the year if you have a qualifying change in family or employment status. Qualifying changes include:
  - A change in your legal marital status,
  - A change in your number of dependents, including:
    - Birth of your child
    - Your legal adoption of a child
    - The legal placement of a child with you for adoption
    - Your dependent child satisfying or ceasing to satisfy eligibility requirements for coverage
    - The death of your dependent child or spouse
  - Your change in employment status or that of your spouse or dependent child

Please keep in mind that the change in coverage you wish to make must be consistent with the change in status. In addition, you must notify Human Resources of the change within 30 days of the change in status.

Enrollment Forms

**Don’t forget to enroll by the deadline!**

Change Requests

**Don’t be late! Make your changes within the allotted timeframe!**

## HELPFUL DEFINITIONS

**Calendar Year** – January 1st through December 31st of each year.

**Coinsurance** – The percent of eligible charges that the plan pays.

**Copayment (Copay)** – The amount paid by a covered person to a network provider at the time services are rendered. Copayments for covered services are not applied to your deductible.

**Deductible** – The amount you pay each calendar year before the plan begins to pay for certain covered health care expenses.

**Guarantee Issue** – The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

**Medical Emergency** – A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.

**Network Benefits** – The benefits applicable for the covered services of a network provider.

**Non-Network Benefits** – The benefits applicable for the covered services of a non-network provider.

**Open Enrollment** – The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.

**Out-of-Pocket Maximum** – The most a covered person can pay in coinsurance in a calendar year for cov- ered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and co-pays).

**Plan Year –** Medical runs May 1 through April 30. Non-medical runs October 1st through September 30th.

**Preferred Provider Organization (PPO)** – A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a network or non-network provider, but network care is covered at a higher benefit level and the employee is responsible for a greater portion of the cost when using a non-network provider.

**Usual and Customary Rates** – Non-network health plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant.

**Using In-Network / Preferred Providers helps YOU SAVE MONEY!!**

## 2020-2021 Per Paycheck Deductions – Medical/Dental/Vision

| Evolution / Multiplan Medical $5000 Deductible Plan | 0-3 Years | | 3-7 Years | | 7+ Years | |
|---|---|---|---|---|---|---|
| | Hourly | Salaried | Hourly | Salaried | Hourly | Salaried |
| Employee | $49.54 | $53.67 | $44.59 | $48.30 | $39.63 | $42.94 |
| Employee + Spouse | $112.09 | $121.43 | $100.88 | $109.29 | $89.67 | $97.15 |
| Employee + Child(ren) | $100.94 | $109.36 | $90.85 | $98.42 | $80.76 | $87.48 |
| Employee + Family | $143.68 | $155.65 | $129.31 | $140.08 | $114.94 | $124.52 |

| Evolution / Multiplan Medical $2500 Deductible Plan | 0-3 Years | | 3-7 Years | | 7+ Years | |
|---|---|---|---|---|---|---|
| | Hourly | Salaried | Hourly | Salaried | Hourly | Salaried |
| Employee | $91.24 | $98.85 | $82.12 | $88.96 | $72.99 | $79.08 |
| Employee + Spouse | $200.60 | $217.31 | $180.54 | $195.58 | $160.48 | $173.85 |
| Employee + Child(ren) | $181.81 | $196.97 | $163.63 | $177.27 | $145.45 | $157.57 |
| Employee + Family | $271.04 | $293.63 | $243.94 | $264.27 | $216.83 | $234.90 |

| BCBS - Dental Plan | Hourly | Salaried |
|---|---|---|
| Employee | $ 8.83 | $ 9.57 |
| Employee + 1 | $ 18.23 | $ 19.75 |
| Employee + Family | $ 36.66 | $ 39.72 |

| Dearborn - Vision Plan | Hourly | Salaried |
|---|---|---|
| Employee | $ 3.47 | $ 3.76 |
| Employee + 1 | $ 6.60 | $ 7.15 |
| Employee + Child(ren) | $ 6.95 | $ 7.53 |
| Employee + Family | $ 10.22 | $ 11.07 |

| DEARBORN BASIC LIFE & AD&D INSURANCE |
| --- |
| 100% Employer Paid |
| **DEARBORN VOLUNTARY LIFE & AD&D INSURANCE** |
| Please see rates listed in Life and AD&D Section |
| **DEARBORN SHORT TERM DISABILITY INSURANCE** |
| Employee Paid - $0.64/$10 of Coverage |
| **DEARBORN LONG TERM DISABILITY INSURANCE** |
| Employee Paid - $0.37/$100 of Coverage |
| **LEGAL SHIELD IDENTITY THEFT PROTECTION AND LEGAL SERVICES** |
| Please see rates listed in Legal Shield Section |
| **NEXSTEP MEDICAL GAP COVERAGE FOR DEDUCTIBLES** |
| Please see rates listed in GAP Section. |

## Medical Benefits – Evolution / Multiplan

| **$5,000 Deductible Medical Plan** | | |
|---|---|---|
| Lifetime Maximum | Unlimited | |
| | | |
| Calendar Year Deductible | Multiplan Provider | Other Provider |
| Individual | $5,000 | $10,000 |
| Family limit | $10,000 | $20,000 |
| Coinsurance | 80% | 60% |
| Out-of-Pocket Maximum (includes deductible) | | |
| Individual | $5,600 | $20,000 |
| Family limit | $11,200 | $40,000 |
| Hospital Services | | |
| Inpatient | 80% of allowable amt. | 60% after ded. |
| Outpatient Surgery | 80% after ded. | 60% after ded. |
| Primary Care Office Visit | $35 copay | 60% after ded. |
| Specialist Office Visit | $45 copay | 60% after ded. |
| Urgent Care Visit | $55 copay | 60% after ded. |
| Preventive Care Services | 100% | 60% after ded. |
| Emergency Room - Accident | $150 copy; then 80% ded waived | $150 copy; then 80% ded waived |
| Skilled Nursing Facility *(25 days per cal year)* | 80% after ded. | 60% after ded. |
| Home Health Care *(60 visits per cal year)* | 80% after ded. | 60% after ded. |
| Mental & Nervous/Substance Abuse | | |
| Hospital Inpatient | 80% of allowable amt. | 60% after ded. |
| Outpatient | $45 Copay | 60% after ded. |
| Prescription Drug Program | | |
| Rx Drug Deductible (Applies to Brand Name Drugs Only) | $150 per individual/$350 per family | |
| Rx Drug Out-of-Pocket Maximum | $1,000 per Individual/$2,000 per Family | |
| Prescription Drugs Retail *(up to 30-day supply)* | Caremark | Other Provider |
| Preferred Generic | $20 | 60% after $20 copay |
| Preferred Brand | $40 | 60% after $40 copay |
| Non-Preferred | $60 | 60% after $60 copay |
| Mail Order Drugs (*30-day supply)* | Caremark | Other Provider |
| Preferred Generic | $20 | Not Covered |
| Preferred Brand | $40 | |
| Non-Preferred | $60 | |

## Medical Benefits – Evolution / Multiplan

| **$2,500 Deductible Medical Plan** | | |
|---|---|---|
| Lifetime Maximum | Unlimited | |
| | | |
| Calendar Year Deductible | Multiplan Provider | Other Provider |
| Individual | $2,500 | $7,500 |
| Family limit | $5,000 | $15,000 |
| Coinsurance | 90% | 70% |
| Out-of-Pocket Maximum (includes deductible) | | |
| Individual | $5,000 | $22,500 |
| Family limit | $10,000 | $45,000 |
| Hospital Services | | |
| Inpatient | 90% of allowable amt. | 70% after ded. |
| Outpatient Surgery | 90% after ded. | 70% after ded. |
| Primary Care Office Visit | $25 copay | 70% after ded. |
| Specialist Office Visit | $40 copay | 70% after ded. |
| Urgent Care Visit | $50 copay | 70% after ded. |
| Preventive Care Services | 100% | 70% after ded. |
| Emergency Room - Accident | $150 copay; then 90% ded waived | $150 copay; then 90% ded waived |
| Skilled Nursing Facility *(25 days per cal year)* | 90% after ded. | 70% after ded. |
| Home Health Care *(60 visits per cal year)* | 90% after ded. | 70% after ded. |
| Mental & Nervous/Substance Abuse | | |
| Hospital Inpatient | 90% of allowable amt. | 70% after ded. |
| Outpatient | $40 Copay | 70% after ded. |
| Prescription Drug Program | | |
| Rx Drug Deductible (Applies to Brand Name Drugs Only) | $150 per individual/$350 per family | |
| Rx Drug Out-of-Pocket Maximum | $1,000 per Individual/$2,000 per Family | |
| Prescription Drugs Retail *(up to 30-day supply)* | Caremark | Other Provider |
| Preferred Generic | $15 | 70% after $15 copay |
| Preferred Brand | $35 | 70% after $35 copay |
| Non-Preferred | $55 | 70% after $55 copay |
| Mail Order Drugs (*30-day supply)* | Caremark | Other Provider |
| Preferred Generic | $15 | Not Covered |
| Preferred Brand | $35 | |
| Non-Preferred | $55 | |

| Medical Gap Coverage | Special Insurance Services (SIS) |
|---|---|

Medical GAP coverage is intended to help you offset out of pocket costs associated with deductibles and out of pocket maximums in certain scenarios.

| Maximum Indemnity Benefit (per insured) | Up to $2,000, or $5,000 per Calendar Year |
|---|---|
| Outpatient Benefit (per Sickness or Injury) | Up to $2,000– Max. of 4 Occurrences per Family/Year |
| Physician Benefit (per physician visit) | Not Covered |
| Wellness Benefit (per family) | Not Covered |
| *All Benefits are subject to Exclusions and Limitations as outlined in the policy.* | |

**GAP Supplemental Insurance - Per Check Payroll Deductions**

| $2000 Plan | Under 40 | | 40-49 | | 50 + | |
|---|---|---|---|---|---|---|
| | *Bi-Weekly* | *Semimonthly* | *Bi-Weekly* | *Semimonthly* | *Bi-Weekly* | *Semimonthly* |
| ***Employee Only*** | $13.55 | $12.51 | $17.15 | $15.83 | $35.14 | $32.44 |
| ***Employee + Spouse*** | $24.39 | $22.51 | $30.87 | $28.50 | $63.22 | $58.36 |
| ***Employee + Children*** | $31.95 | $29.49 | $38.42 | $35.46 | $59.48 | $54.90 |
| ***Employee + Family*** | $42.77 | $39.48 | $50.72 | $46.82 | $87.92 | $81.16 |

| $5000 Plan | Under 40 | | 40-49 | | 50 + | |
|---|---|---|---|---|---|---|
| | *Bi-Weekly* | *Semimonthly* | *Bi-Weekly* | *Semimonthly* | *Bi-Weekly* | *Semimonthly* |
| ***Employee Only*** | $20.97 | $19.36 | $26.57 | $24.53 | $54.32 | $50.14 |
| ***Employee + Spouse*** | $37.76 | $34.86 | $47.83 | $44.15 | $97.76 | $90.24 |
| ***Employee + Children*** | $51.73 | $47.75 | $53.69 | $49.56 | $95.66 | $88.30 |
| ***Employee + Family*** | $68.50 | $63.23 | $74.92 | $69.16 | $143.56 | $132.52 |

| Dental Benefits | BCBS of Texas | |
|---|---|---|
| **First You Pay a Calendar Year Deductible of:** | **MAC Plan** | **U&C Plan** |
| Individual/Family | $50/$150 per family | |
| **Then the Plan Pays:** | | |
| Preventive Services | | |
| Oral Exams, Bitewing X-Rays, Full Mouth X-Rays<br>Prophylaxis/Cleaning, Fluoride Treatments | 100% | 100% |
| Basic Services | | |
| Fillings, Non-surgical extractions | 100% | 80% |
| Other Services | | |
| Root canals, Crowns, Endodontic Services, Oral Surgery, Dentures, Bridges | 60% | 50% |
| Calendar Year Maximum Benefit | $1,500 | $1,500 |
| Orthodontics – Lifetime Maximum<br>Orthodontia | $1,500<br>50% | $1,500<br>50% |

**Maximum Allowable Coverage Plan (MAC) vs. Usual & Customary Plan (U&C)**

The MAC Plan is great if your dental providers are in-network with BCBS. Under the MAC Plan, preventive **and** basic services will be covered at 100% while other, more extensive services with in-network providers would be covered at 60%. If you choose to go to an out-of-network provider, however, the MAC plan only pays 60% *of the rate allowed by BCBS' fee schedule*. If your provider charges more than that fee, you will be responsible for 40% of the BCBS rate PLUS the difference between the BCBS rate and the rate your provider charges.

In contrast, the U&C Plan is a better deal if your favored provider is out-of-network. Under the U&C Plan, preventative services are still covered at 100%, but basic services are covered at 80% and other, more extensive services are covered at 50%. When it comes to out-of-network providers, however, those reduced percentages are based on the usual and customer fees for the area – **not** BCBS' rate.

For example, say you needed to have a tooth extracted, which is covered under the MAC Plan at 60% and under the U&C Plan at 50%, and that the BCBS negotiated rate for a tooth extraction is $1000. If your dental provider is in the BCBS network, your cost under each plan would be $400 under the MAC Plan and $500 under the U&C Plan.

But let's say that your dental provider is not in the BCBS network, and that his fee for a tooth extraction matches the usual and customary rate for your area at $1500. In this scenario, your cost under the MAC Plan would be 40% of the $1000 BCBS rate PLUS the $500 difference between the BCBS rate and your provider's rate – bringing your total cost to $900. Under the U&C Plan, your cost would simply be 50% of the provider's rate – $750.

The differences can be summarized as follows:

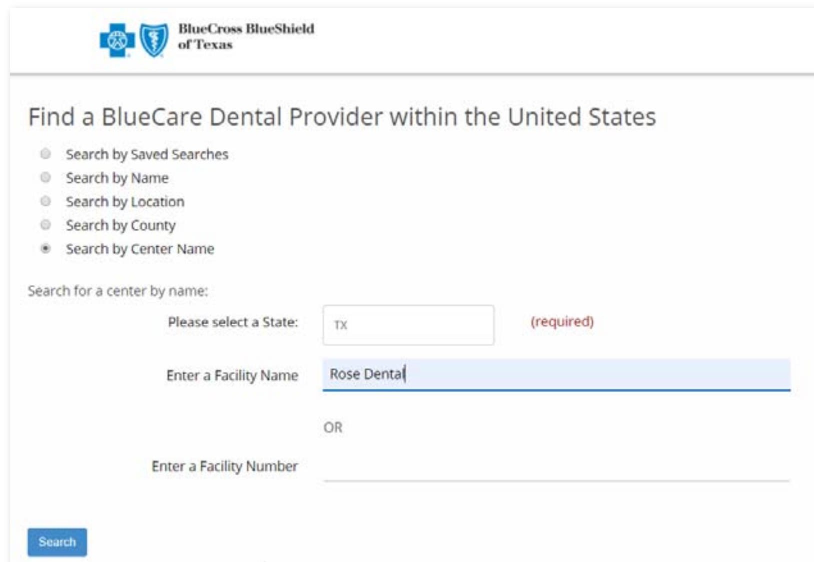
| | MAC Plan | U&C Plan |
|---|---|---|
| **In-network** | Benefits are based on a negotiated fee schedule. No additional fees to the dentist | |
| **Out-of-network** | • Benefits are based on the BCBS network fee schedule<br>• Any amount that is charged over the network fee schedule is the responsibility of the patient | • Benefits are based on usual and customary charges that dentists in your area charge for each procedure |

**How to determine if your Dental Provider is in BCBS' Network**

Go to www.bcbstx.com/find-a-doctor-or-hospital and login or click on "**Search as Guest**".

- Under *Helpful Links* scroll all the way down and click on "**Find a Dentist**"
- Click on "**BlueCare Dental**"

Once you get to the Find a BlueCare Dental Provider page, you can choose how you would like to search (by location, provider name, center name, etc.), enter the applicable info and then click on "Search"




If your provider is in the resulting list, that means they are in-network.

| Vision Benefits | BCBS of TX |
|---|---|

| Vision Care Service | Member Cost In-Network | Out of Network Reimbursement |
|---|---|---|
| Exam with Dilation as Necessary | $10 Copay | Up to $30 |
| Frequency: | | |
| Examination | Once every 12 months | |
| Lenses or Contact Lenses | Once every 12 months | |
| Frame | Once every 24 months | |
| Exam Options: | | |
| Standard Contact Lens Fit and Follow Up: | Up to $40 for Standard; 10% off retail price for Premium | N/A |
| Frames: | | |
| Any available frame at provider location | $0 Copay; **$130** Allowance, 20% off balance over $130 | Up to $65 |
| Standard Plastic Lenses | | |
| Single Vision | $10 Copay | Up to $25 |
| Bifocal | $10 Copay | Up to $40 |
| Trifocal | $10 Copay | Up to $55 |
| Lenticular | $10 Copay | Up to $55 |
| Standard Progressive Lens | $75 Copay | Up to $40 |
| Premium Progressive Lens | See table on page 2 | Up to $40 |
| Lens Options | | |
| UV treatment | $15 | N/A |
| Tint (solid and gradient) | $15 | N/A |
| Standard Plastic Scratch Coating | $0 | Up to $5 |
| Standard Polycarbonate – Adults | $40 | N/A |
| Standard Polycarbonate – Kids under 19 | $0 | Up to $5 |
| Standard Anti-Reflective Coating | $45 | N/A |
| Polarized | 20% off retail price | N/A |
| Photocromatic/Transitions Plastic | $75 | N/A |
| Premium Anti-reflective | See Below Table | N/A |
| Contact Lenses (Contact lens allowance includes materials only) | | |
| Conventional | $0 Copay; $130 allowance, 15% off balance over $130 | Up to $104 |
| Disposable | $0 Copay; $130 allowance, plus balance over $130 | Up to $104 |
| Medically Necessary | $0 Copay, Paid in full | Up to $210 |
| Laser Vision Correction | | |
| Lasik or PRK from U.S. Laser Network | 15% off Retail Price or 5% off Promotional Price | N/A |
| Additional Pairs Benefit: | Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used. | N/A |

**How to determine if your Vision Provider is in the EyeMed Network**

- Go to www.dearbornnational.com/vision/
- Scroll all the way down and click on "**For all other employer groups** click here."
- Enter your zip code and click on "**Get Results**"
- Alternatively, you can enter your zip code then click on "**Advanced Search**" to search by Provider Name, Specialty, Gender, Hours, Services, etc.
- Click "**Search**"

Dearborn National
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Begin Your Search

ZIP Code * Or Use My Location

What else is important?

Get Results

Advanced Search

* Required Field

Provider Locator

Let's focus on what works best for you.

Enter the information that fits your network and location.

What will I see?

Dearborn National Vision Care members have access to the EyeMed Network. You will see a variety of providers and where they are located. Even if a provider is displayed, we recommend you call ahead to confirm the provider accepts your Dearborn National Vision Care plan.

# Dearborn Basic Life and AD&D Insurance

Employees eligible are active full-time employees working 30 hours or more per week.

***Basic Life Insurance:***

Republic Plastics pays for and provides Basic Life Insurance for all full time employees in the amount of $15,000.

***Accidental Death & Dismemberment:***

Accidental Death benefits are payable to your beneficiary, in addition to your Life Insurance benefit, if you die within 365 days after a covered accident and the cause of your death can be attributed to the covered accident. Accidental Dismemberment benefits are payable to you if you suffer a loss that is covered under the plan. The loss must have occurred within 365 days of the covered accident.

| | Basic AD&D Benefit |
|---|---|
| Loss of Life | 100% |
| Loss of Both Hands, Feet, or Eyes | 100% |
| Loss of Hand, Foot, or an Eye | 100% |
| Loss of thumb and index finger of same hand | 25% |

# Dearborn / Supplement Life & AD&D

| For You | For Your Spouse | For Your Child(ren) |
|---|---|---|
| *You must purchase coverage for yourself to purchase coverage for your family.* | *Spouse coverage cannot exceed the employee coverage.* | *Coverage begins on Day 1* |
| **Amount of Coverage** | **Amount of Coverage** | **Amount of Coverage** |
| Increments of $10,000 | Increments of $5,000 | Increments of $2000 |
| Maximum is $500,000 or 7 x Salary - whichever is less | Maximum is the Lesser of 100% of Employee amount or $500,000 | Maximum is $10,000 |
| Guarantee Issue is $150,000 | Guarantee Issue is $30,000 | Guarantee Issue is $10,000 |

Employees have the ability to elect additional coverage for themselves and their dependents up to the guaranteed issued amount without having to provide Evidence of Insurability if coverage is elected within 30 days of your date of eligibility. Proof of good health is required if you enroll for coverage over the guarantee issue amount, or if you do not enroll within 30 days from your initial date of eligibility.

***Supplemental Life Insurance***

If you want a greater level of protection, Supplemental Life Insurance coverage is available to purchase. Life doesn't always bring us what we expect. It helps to know that **financial security** is available for your family…even if you aren't. But not everyone has the same need for protection. That's why Republic Plastics provides you with the opportunity to elect Supplemental Life Insurance on yourself as well as for your family.

*Please Note: You must enroll in Employee Supplemental Life to enroll in spouse or child Supplemental Life. Spouse Supplemental Life cannot exceed 100% of the Employee Supplemental Life.

**Some things in life are too important to pass up! Elect the appropriate amount of coverage now to protect your family's financial needs.**

# Dearborn / Supplement Life & AD&D

Voluntary Life monthly premiums for you and your spouse are based on the amount of coverage chosen and your age.

| Employee's Age | Rate per $1000 of coverage |
|---|---|
| 25-29 | $0.048 |
| 30-34 | $0.048 |
| 35-39 | $0.073 |
| 40-44 | $0.145 |
| 45-49 | $0.235 |
| 50-54 | $0.371 |
| 55-59 | $0.581 |
| 60-64 | $0.937 |
| 65-69 | $1.510 |
| 70-74 | $2.390 |
| 75-79 | $2.390 |

Child Life monthly premiums are $0.147 per $1000 of coverage. Employee, Spouse, and Child AD&D premiums are $0.025 per $1000 of coverage.

You can see what your per check premiums would be in the Fidelity enrollment tool.

# Dearborn Disability Insurance

Long-Term Disability & Short Term Disability provides the protection you need to ensure that your way of life is protected in case of a serious injury or illness. The following is a summary of the LTD & STD disability plans offered through Dearborn. Employees eligible are full time employees working 30 hours or more per week.

| Dearborn | STD Benefit |
| --- | --- |
| Basic Benefit | 60% of salary |
| Maximum Weekly Benefit | $600 |
| Maximum Benefit Duration | 25 weeks |
| Benefits Begin | 8th day |
| Pre-existing Conditions | 3/12 |

| Dearborn | LTD Benefit |
| --- | --- |
| Basic Benefit | 60% of salary |
| Maximum Monthly Benefit | $6,000 |
| Elimination Period | 180 days |
| Pre-existing Conditions | 3/12 |

# LegalShield

## Identity Theft Protection and Pre-paid Legal Services

LegalShield offers both identity theft protection and pre-paid legal services to associates and their family members. LegalShield's identify theft protection benefits helps to prevent and resolve issues related to identity theft and, for an additional premium, can include such services as credit monitoring and credit alerts. LegalShield also provides pre-paid legal services which allow employees 24/7 access to licensed attorneys who can provide legal advice and assistance on a variety of legal matters. Associates can elect to purchase either the identify theft benefits, or the pre-paid legal services benefits or a combination of both.

| Type of Coverage | Per-check Premium | |
|---|---|---|
| | Bi-Weekly | Semi-monthly |
| Identity Theft Shield | $6.48 | $7.02 |
| Identity Theft Shield + children | $6.98 | $7.56 |
| Identity Theft Shield Premium | $12.48 | $13.52 |
| Identity Theft Shield Premium + children | $12.98 | $14.06 |
| Legal Shield | $7.88 | $8.54 |
| Legal Shield + Identity Theft Shield | $12.85 | $13.92 |
| Legal Shield + Identity Theft Shield + children | $13.35 | $14.46 |
| Legal Shield + Identity Theft Shield Premium | $17.85 | $19.34 |
| Legal Shield + Identity Theft Shield Premium + children | $18.35 | $19.88 |

# Important Contacts

If you have any questions about any of your benefits, below is a list of the plans, the companies who administer them, and their phone numbers and websites:

| Plan | Company | Phone Number | Website |
|---|---|---|---|
| Medical | Evolution / MultiPlan | (833) 380-8106 | www.myevhc.com |
| Dental | BCBS of TX | (800) 521-2227 | www.bcbstx.com |
| Vision | Dearborn | (800) 348-4512 | www.dearbornnational.com |
| LTD & STD | Dearborn | (800) 348-4512 | www.dearbornnational.com |
| Basic Life & AD&D, Voluntary Life | Dearborn | (800) 348-4512 | www.dearbornnational.com |
| Medical GAP | NexStep | (800) 767-6811 | n/a |
| LegalShield | LegalShield | (888) 494-8519 (IdentityShield) 800-654-7757 (LegalShield) | www.legalshield.com |

For additional support or questions regarding your health and welfare benefits, please contact:

(855) 889-3713
scr-support@alliant.com
Monday – Thursday 8:00 am – 5:30 pm CST / Friday 8:00 am – 5:00 pm

*This benefit booklet summarizes the provisions of the benefits of choice for Republic Plastics effective October 1, 2019. Complete details of the plan are included in the official plan documents and contracts. If there is a difference between this book and the documents or contracts, then the documents and contracts will govern. Benefits described in this book may be changed at any time and do not represent a contractual obligation on the part of Republic Plastics.*