2022 MEDICAL PLAN COMPARISONS

	Pineapple Premier Plan (Aetna)			Pineapple Basic Plan (UnitedHealthcare)	
Services	**Baptist Health Network***	**National Network** (POS II Network)	**Out-of-Network** (Not contracted with Aetna)	**National Network** (Choice Plus Network)	**Out-of-Network** (Not contracted with UnitedHealthcare)
Deductible Credit	If eligible, employee and spouse can **each** earn up to $1,000 in credits. If your coverage is Employee and Child(ren), the same amount you earn will be applied toward the family deductible.		Not applicable	Up to $100	Not applicable
Deductible	$1,000 individual / $2,000 family		$3,000 individual / $6,000 family	$300 individual / $600 family	$900 individual / $1,800 family
Out-of-Pocket Maximum **Includes deductible and copays including pharmacy copays	$2,000 individual**/ $4,000 family**		$4,000 individual / $8,000 family	$2,000 individual**/ $4,000 family**	$4,000 individual / $8,000 family
Primary Care Physician (PCP)	No PCP designation or referral required			No PCP designation or referral required	
Preventive Care Services such as annual physical exams, colorectal cancer screenings, mammograms and HIV screenings	No charge	No charge	Not covered	No charge	Not covered
Office Visit	No charge after deductible	$20 copay after deductible	50% coinsurance after deductible	No charge after deductible for in-network primary care physician (PCP) in the Baptist Health Network* $20 copay after deductible if not in Baptist Health Network	50% coinsurance after deductible
Office Visit – Specialist	$15 copay after deductible	$40 copay after deductible	50% coinsurance after deductible	$40 copay after deductible	50% coinsurance after deductible
Maternity Office Visit	No charge after deductible	$20 copay after deductible for first visit only	50% coinsurance after deductible	$20 copay after deductible for first visit only	50% coinsurance after deductible
Chiropractor Office Visit / Spinal Manipulation	$15 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	$40 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	50% coinsurance after deductible (limited to 20 visits per year for in-network and out-of-network combined)	$40 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	50% coinsurance after deductible (limited to 20 visits per year for in-network and out-of-network combined)
Lab Services	No charge	No charge at an in-network lab	50% coinsurance after deductible	No charge at a Baptist Health lab or an in-network lab	50% coinsurance after deductible
Low-End Diagnostics such as X-rays and ultrasounds	No charge after deductible	$25 copay after deductible	50% coinsurance after deductible	$25 copay after deductible	50% coinsurance after deductible

2022 MEDICAL PLAN COMPARISONS

	Pineapple Premier Plan (Aetna)			Pineapple Basic Plan (UnitedHealthcare)	
Services	**Baptist Health Network***	**National Network** (POS II Network)	**Out-of-Network** (Not contracted with Aetna)	**National Network** (Choice Plus Network)	**Out-of-Network** (Not contracted with UnitedHealthcare)
High-End Diagnostics such as CT scan, MRI and MRA	$150 copay	$750 copay after deductible at an in-network non-Baptist Health provider	50% coinsurance after deductible	$150 copay at a Baptist Health provider $750 copay after deductible at an in-network non-Baptist Health provider	50% coinsurance after deductible
Nuclear Medicine and PET	$150 copay	Broward County residents: $150 copay at an in-network provider $750 copay after deductible at an in-network non-Baptist Health provider	50% coinsurance after deductible	$150 copay at a Baptist Health provider Broward County residents: $150 copay at an in-network provider $750 copay after deductible at an in-network non-Baptist Health provider	50% coinsurance after deductible
Emergency Room Service Waived if admitted. Non-emergency is not covered.	$200 copay after deductible	$200 copay after deductible	$200 copay after deductible	$200 copay after deductible	$200 copay after deductible
Ambulance Services	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible
Urgent Care Centers	$75 copay after deductible	$100 copay after deductible	50% coinsurance after deductible	$75 copay after deductible at a Baptist Health facility $100 copay after deductible at an in-network provider	50% coinsurance after deductible
Baptist Health Care On Demand – Virtual Urgent Care	No charge for Baptist Health Care On Demand	No charge for Baptist Health Care On Demand	No charge for Baptist Health Care On Demand	No charge for Baptist Health Care On Demand	No charge for Baptist Health Care On Demand
Hospital Admission	$75 copay per day, up to 5 days after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible
Bariatric Surgery Weight-Loss Surgery Program at South Miami Hospital only. Must meet eligibility program criteria to be covered.	$1,400 copay after deductible	Not covered	Not covered	$1,400 copay after deductible	Not covered

2022 MEDICAL PLAN COMPARISONS

	Pineapple Premier Plan (Aetna)			Pineapple Basic Plan (UnitedHealthcare)	
Services	**Baptist Health Network***	**National Network** (POS II Network)	**Out-of-Network** (Not contracted with Aetna)	**National Network** (Choice Plus Network)	**Out-of-Network** (Not contracted with UnitedHealthcare)
Outpatient Surgery including diagnostic endoscopy and colonoscopy procedures	$250 copay Colonoscopies covered at no charge	Broward County residents: $250 copay at an in-network provider $750 copay after deductible at an in-network non-Baptist Health provider Colonoscopies covered at no charge	50% coinsurance after deductible	$250 copay at a Baptist Health provider Broward County residents: $250 copay at an in-network provider $750 copay after deductible at an in-network non-Baptist Health provider Colonoscopies covered at no charge	50% coinsurance after deductible
Chemotherapy – Outpatient	$30 copay after deductible	$100 copay after deductible	50% coinsurance after deductible	$100 copay after deductible	50% coinsurance after deductible
Radiation Therapy – Outpatient	No charge after deductible	$30 copay after deductible	50% coinsurance after deductible	$30 copay after deductible	50% coinsurance after deductible
Rehabilitation Services – Physical, speech and occupational	No charge after deductible (90 visits combined per year)	$20 copay after deductible (90 visits combined per year)	50% coinsurance after deductible	$20 copay after deductible (90 visits combined per year)	50% coinsurance after deductible
Acupuncture	$15 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	$40 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	50% coinsurance after deductible	$40 copay after deductible (limited to 20 visits per year for in-network and out-of-network combined)	50% after deductible (limited to 20 visits per year for in-network and out-of-network combined)
Sleep Study	No charge after deductible	$25 copay after deductible	50% coinsurance after deductible	$25 copay after deductible	50% coinsurance after deductible
Allergy Shots	No charge after deductible	$20 copay after deductible at PCP office; $40 copay after deductible at specialist office. Copay waived if injection only.	50% coinsurance after deductible	$20 copay after deductible at PCP office; $40 copay after deductible at specialist office. Copay waived if injection only.	50% coinsurance after deductible
Home Health	No charge after deductible (limited to 60 visits per year for in-network and out-of-network combined)	No charge after deductible (limited to 60 visits per year for in-network and out-of-network combined)	50% coinsurance after deductible (limited to 60 visits per year for in-network and out-of-network combined)	No charge after deductible (limited to 60 visits per year for in-network and out-of-network combined)	50% coinsurance after deductible (limited to 60 visits per year for in-network and out-of-network combined)
Durable Medical Equipment (DME)	10% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible

2022 MEDICAL PLAN COMPARISONS

	Pineapple Premier Plan (Aetna)			2022 Pineapple Basic Plan (UnitedHealthcare)	
Services	**Baptist Health Network***	**National Network** (POS II Network)	**Out-of-Network** (Not contracted with Aetna)	**National Network** (Choice Plus Network)	**Out-of-Network** (Not contracted with UnitedHealthcare)
Autism Spectrum Disorder – Applied Behavioral Analysis (ABA)	No charge	No charge	50% coinsurance after deductible	No charge	50% coinsurance after deductible
Autism Spectrum Disorder – Behavioral Therapy	No charge after deductible	$20 copay after deductible	50% coinsurance after deductible	$20 copay after deductible at an in-network provider	50% coinsurance after deductible
Autism Spectrum Disorder – Physical, Occupational and Speech Therapy	No charge after deductible	$20 copay after deductible	Not covered	$20 copay after deductible at an in-network provider	Not covered
Mental Health / Substance Use Disorder – Inpatient	$75 copay per day, up to 5 days after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible
Mental Health / Substance Use Disorder – Outpatient / Partial Hospitalization	No charge	No charge	50% coinsurance after deductible	No charge	50% coinsurance after deductible
Mental Health / Substance Use Disorder – Therapy Visits	$20 copay after deductible	$20 copay after deductible	50% coinsurance after deductible	$20 copay after deductible	50% coinsurance after deductible
For uncovered services, discount off Baptist Health facility charges excluding physician / provider charges	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	Not covered
Prescriptions					
Generic	$15	$15	Covered at in-network pharmacy only	$15	Covered at in-network pharmacy only
Preferred	$30	$30		$30	
Non-Preferred Brand	$50	$50		$50	
Specialty	$75	$75		$75	
Baptist Health Pharmacies*	90-day supply 1x copay				
CVS Mail Order	90-day supply 3x copay				

*Baptist Health Network includes all Baptist Health facilities, Baptist Health Medical Group, Baptist Health Quality Network, and the Baptist Health Medical Group North.
**Employees can fill their prescriptions at a Baptist Health Pharmacy and pay only 1x the copay for a 90-day supply.

2022 MEDICAL PLAN RATE SHEET

2022 MEDICAL PLAN PER PAY CHECK EMPLOYEE CONTRIBUTIONS

DID YOU KNOW On average, Baptist Health spends $10,511 per covered employee per year on healthcare costs – with a projected cost of over $253 million in 2022.

PINEAPPLE PREMIER PLAN MANAGED BY AETNA	FULL-TIME	PART-TIME
Employee Only	$ 49.37	$ 75.80
Employee + Child(ren)	$123.65	$199.67
Employee + Spouse	$176.68	$274.49
Employee + Family	$235.17	$391.89

PINEAPPLE BASIC PLAN MANAGED BY UNITED	FULL-TIME	PART-TIME
Employee Only	$ 76.85	$129.97
Employee + Child(ren)	$180.93	$281.33
Employee + Spouse	$252.40	$350.98
Employee + Family	$303.38	$557.42

2022 MEDICAL PLAN COMPARISONS

	Pineapple Premier Plan (Aetna)			2022 Pineapple Basic Plan (UnitedHealthcare)	
Services	**Baptist Health Network***	**National Network** (POS II Network)	**Out-of-Network** (Not contracted with Aetna)	**National Network** (Choice Plus Network)	**Out-of-Network** (Not contracted with UnitedHealthcare)
Autism Spectrum Disorder – Applied Behavioral Analysis (ABA)	No charge	No charge	50% coinsurance after deductible	No charge	50% coinsurance after deductible
Autism Spectrum Disorder – Behavioral Therapy	No charge after deductible	$20 copay after deductible	50% coinsurance after deductible	$20 copay after deductible at an in-network provider	50% coinsurance after deductible
Autism Spectrum Disorder – Physical, Occupational and Speech Therapy	No charge after deductible	$20 copay after deductible	Not covered	$20 copay after deductible at an in-network provider	Not covered
Mental Health / Substance Use Disorder – Inpatient	$75 copay per day, up to 5 days after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible	$150 copay per day, up to 5 days after deductible	50% coinsurance after deductible
Mental Health / Substance Use Disorder – Outpatient / Partial Hospitalization	No charge	No charge	50% coinsurance after deductible	No charge	50% coinsurance after deductible
Mental Health / Substance Use Disorder – Therapy Visits	$20 copay after deductible	$20 copay after deductible	50% coinsurance after deductible	$20 copay after deductible	50% coinsurance after deductible
For uncovered services, discount off Baptist Health facility charges excluding physician / provider charges	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	20% discount for elective procedures; 50% discount for medically necessary procedures	Not covered
Prescriptions: Generic Preferred Non-Preferred Brand Specialty Baptist Health Pharmacies* – 90-day supply Mail Order – 90-day supply	 $15 $30 $50 $75 1x copay 3x copay	 $15 $30 $50 $75 1x copay 3x copay	Covered at in-network pharmacy only	 $15 $30 $50 $75 1x copay 3x copay	Covered at in-network phamacy only

*Baptist Health Network includes all Baptist Health facilities, Baptist Health Medical Group, Baptist Health Quality Network, Bethesda Custom Network and BocaCare Physician Network.
**Employees can fill their prescriptions at a Baptist Health Pharmacy and pay only 1x the copay for a 90-day supply.

2022 MEDICAL PLAN PER PAYCHECK EMPLOYEE CONTRIBUTIONS

PINEAPPLE PREMIER PLAN MANAGED BY AETNA	FULL-TIME	PART-TIME	PINEAPPLE BASIC PLAN MANAGED BY UNITEDHEALTHCARE	FULL-TIME	PART-TIME
Employee Only	$ 49.37	$ 75.80	Employee Only	$ 76.85	$129.97
Employee + Child(ren)	$123.65	$199.67	Employee + Child(ren)	$180.93	$281.33
Employee + Spouse	$176.68	$274.49	Employee + Spouse	$252.40	$350.98
Employee + Family	$235.17	$391.89	Employee + Family	$303.38	$557.42

NOTE: If you or your dependents are tobacco users, you will pay a $50 per-pay-period smoker surcharge.

2022 DENTAL PLAN COMPARISONS

	MetLife SafeGuard (DHMO)+		MetLife PPO Basic		MetLife PPO		MetLife PPO Monroe
Services	**Basic – SGC1038**	**Basic Plus – SGC1037**	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-/Out-of-Network**
Deductible	None	None	$50 per person $150 per family	$75 per person $225 per family	$50 per person $150 per family	$50 per person $150 per family	$25 per person $75 per family
Office Visit (2 times a year)	$5 copay	$5 copay	No charge	You pay 30%	No charge	You pay 20%	No charge
Oral Exam (2 times a year)	No charge	No charge	No charge	You pay 30%	No charge	You pay 20%	No charge
X-rays Bitewing: one set per year Full mouth: one per 5 years	No charge	No charge	No charge	You pay 30%	No charge	You pay 20%	No charge
Preventive Cleanings (2 times a year)	$5 copay	No charge	No charge	You pay 30%	No charge	You pay 20%	No charge
Extractions	Up to $150 copay	Up to $100 copay	You pay 40% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible
Restoration (fillings)	Amalgam (silver) up to $25 Resin up to $65	Amalgam (silver) up to $25 Resin up to $65	You pay 40% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible
Root Canal	Up to $265 copay	Up to $210 copay	You pay 40% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible
Crown — Porcelain	Up to $290 copay + lab fees	Up to $225 copay + lab fees	You pay 70% after deductible	You pay 75% after deductible	You pay 50% after deductible	You pay 60% after deductible	You pay 50% after deductible
Partial Denture	$405–$480 copay	$365–$400 copay	You pay 70% after deductible	You pay 75% after deductible	You pay 50% after deductible	You pay 60% after deductible	You pay 50% after deductible
Orthodontia	$2,095 copay (adults and children)	$1,695 copay (adults and children)	You pay 50% after deductible (children only) Lifetime maximum up to $1,000	You pay 60% after deductible (children only) Lifetime maximum up to $1,000	You pay 50% after deductible (children only) Lifetime maximum up to $1,000	You pay 50% after deductible (children only) Lifetime maximum up to $1,000	You pay 50% after deductible (children only) Lifetime maximum up to $1,000
Annual Maximum Benefit	Unlimited	Unlimited	$1,000 per person	$750 per person	$3,000 per person	$1,250 per person	$3,000 in-network/ $1,500 out-of-network

**Paid at negotiated fee.*
***Paid at usual and customary fee.*
+These plans are available only to employees who are Florida residents.

PAYING FOR YOUR DENTAL PLAN

Regular Full-Time Employees (Rates are per pay period)			
	Employee	**Employee + 1**	**Family**
MetLife SafeGuard Basic (DHMO)	$ 0.00	$ 2.27	$ 5.02
MetLife SafeGuard Basic Plus (DHMO)	$ 4.03	$ 9.63	$15.13
MetLife PPO Basic	$ 6.02	$ 17.70	$ 24.22
MetLife PPO	$ 12.05	$ 36.90	$ 50.49
MetLife Monroe PPO	$ 12.05	$ 36.90	$ 50.49
Regular Part-Time Employees (Rates are per pay period)			
	Employee	**Employee + 1**	**Family**
MetLife SafeGuard Basic (DHMO)	$ 0.00	$ 3.50	$ 7.60
MetLife SafeGuard Basic Plus (DHMO)	$ 4.49	$ 11.72	$19.41
MetLife PPO Basic	$ 6.52	$ 18.92	$ 25.90
MetLife PPO	$ 13.05	$ 41.66	$ 57.00
MetLife Monroe PPO	$13.05	$ 41.66	$ 57.00

2022 DENTAL PLAN COMPARISONS

	MetLife SafeGuard (DHMO)+		MetLife PPO Basic		MetLife PPO		MetLife PPO Monroe	
Services	**Basic – SGC1038**	**Basic Plus – SGC1037**	**In Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out of Network**
Deductible	None	None	$50 per person $150 per family	$75 per person $225 per family	$50 per person $150 per family	$50 per person $150 per family	$25 per person $75 per family	$25 per person $75 per family
Preventive Cleanings	$5 copay 2 times a year	No charge 2 times a year	No charge 2 times a year	You pay 30%**	No charge 2 times a year	You pay 20%**	No charge 2 times a year	No charge 2 times a year
Restoration (fillings)	Amalgam (silver) up to $25 Resin up to $65	Amalgam (silver) up to $25 Resin up to $65	You pay 40%* after deductible	You pay 50%** after deductible	You pay 20%* after deductible	You pay 40%** after deductible	You pay 20%* after deductible	You pay 20%** after deductible
Orthodontia	$2,095 copay (adults and children)	$1,695 copay (adults and children)	You pay 50%* after deductible (children only) Lifetime maximum up to $1,000	You pay 60%** after deductible (children only) Lifetime maximum up to $1,000	You pay 50%* after deductible (children only) Lifetime maximum up to $1,000	You pay 50%** after deductible (children only) Lifetime maximum up to $1,000	You pay 50%* after deductible (children only) Lifetime maximum up to $1,000	You pay 40%** after deductible (children only) Lifetime maximum up to $1,000
Annual Maximum Benefit	Unlimited	Unlimited	$1,000 per person	$750 per person	$3,000 per person	$1,250 per person	$3,000 per person	$1,500 per person

**Paid at negotiated fee.*
***Paid at usual and customary fee.*
+These plans are available only to employees who are Florida residents.

Regular Full-Time Employees (Rates are per pay period)			
	Employee	**Employee + 1**	**Family**
MetLife SafeGuard Basic (DHMO)	$ 0.00	$ 2.27	$ 5.02
MetLife SafeGuard Basic Plus (DHMO)	$ 4.03	$ 9.63	$15.13
MetLife PPO Basic	$ 6.02	$ 17.70	$ 24.22
MetLife PPO	$ 12.05	$ 36.90	$ 50.49
MetLife Monroe PPO	$ 12.05	$ 36.90	$ 50.49
Regular Part-Time Employees (Rates are per pay period)			
	Employee	**Employee + 1**	**Family**
MetLife SafeGuard Basic (DHMO)	$ 0.00	$ 3.50	$ 7.60
MetLife SafeGuard Basic Plus (DHMO)	$ 4.49	$ 11.72	$19.41
MetLife PPO Basic	$ 6.52	$ 18.92	$ 25.90
MetLife PPO	$ 13.05	$ 41.66	$ 57.00
MetLife Monroe PPO	$ 13.05	$ 41.66	$ 57.00

2022 VISION PLAN DETAILS

EyeMed		
Services	**In-Network**	**Out-of-Network (reimbursed up to)**
Exam at a PLUS Provider Exam With Dilation	$0 copay $10 copay	$35
Retinal Imaging	Up to $39	N/A
Standard Plastic Lenses		
Single Vision Lens	$10 copay	$20
Bifocal Lens	$10 copay	$40
Trifocal Lens	$10 copay	$60
Standard Progressive Lens	$10 copay	$100
Premium Progressive Tier 1 Tier 2 Tier 3 Tier 4	 $30 copay $40 copay $55 copay $10 copay (80%of charge less $120 allowance)	 All tiers $100
Frames at a PLUS Provider	$215 allowance; 20% off balance over $215	$50
Frames	$165 allowance; 20% off balance over $165	$50
Lens Options: UV Coating	$15	N/A
Lens Options: Tint	$15	N/A
Lens Options: Scratch-Resistant Coating	$0 copay	$8
Lens Options: Standard Polycarbonate	$40	N/A
Standard Anti-Reflective Premium Tier 1 Premium Tier 2	$45 $57 $68	N/A
Contact Lenses Disposable	$165 allowance with a $0 copay	$100
Contact Lenses Conventional	$165 allowance with a $0 copay; 15% off balance	$100
Contact Lenses Medically Necessary	Paid in full	$200
Frequency of Examinations	Once every calendar year	Once every calendar year
Frequency of Frame Replacement	Once every calendar year	Once every calendar year
Frequency of Lens Changes (eyeglasses or contact lenses)	Once every calendar year	Once every calendar year
LASIK and PRK Correction	15% off retail price or 5% off promotional price	N/A

Vision plan rates

Vision Plan	Employee	Employee + 1	Family
EyeMed	$2.76	$7.12	$11.48

2022 LEGAL PLAN COMPARISONS

METLIFE LEGAL PLAN

The legal plan provides full coverage of attorney fees for the most common personal legal matters with no additional out-of-pocket cost to employees.

	Classic Plan	Premier Plan	
Money Matters	• Debt Collection Defense • Identity Management Services • Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy • Promissory Notes • Tax Collection Defense	• Debt Collection Defense • Identity Management Services • Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy • Promissory Notes	• Tax Collection Defense • Financial Education Workshops • Tax Audit Representation
Home & Real Estate	• Deeds • Eviction Defense • Foreclosure • Mortgages • Security Deposit Assistance • Tenant Negotiations	• Deeds • Eviction Defense • Foreclosure • Mortgages • Security Deposit Assistance • Tenant Negotiations	• Boundary & Title Disputes • Property Tax Assessments • Refinancing & Home Equity Loan • Sale or Purchase of Home • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) • Revocable & Irrevocable Trusts • Simple Wills	• Codicils • Complex Wills • Healthcare Proxies • Living Wills • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) • Revocable & Irrevocable Trusts	• Simple Wills • Probate
Family & Personal	• Affidavits • Conservatorship • Demand Letters • Divorce (Uncontested) • Garnishment Defense • Guardianship • Name Change • Personal Properties Issues • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings	• Affidavits • Conservatorship • Demand Letters • Divorce (Uncontested) • Garnishment Defense • Guardianship • Name Change • Personal Properties Issues • Protection from Domestic Violence • Review of ANY Personal Legal Document	• School Hearings • Adoption • Divorce (Contested) • Immigration Assistance • Juvenile Court Defense, Including Criminal Matters • Parental Responsibility Matters • Prenuptial Agreement
Civil Lawsuits	• Administrative Hearings • Disputes Over Consumer Goods & Services • Incompetency Defense • Small Claims Assistance	• Administrative Hearings • Disputes Over Consumer Goods & Services • Incompetency Defense • Small Claims Assistance	• Civil Litigation Defense • Pet Liabilities
Elder-care Issues	Same as Premier Plan	Consultation & Document Review for Issues Related to Your Parents: • Deeds • Leases • Medicaid • Medicare	• Notes • Nursing Home Agreements • Powers of Attorney • Prescription Plans • Wills
Traffic and Other Matters	Same as Premier Plan	•Defense of Traffic Tickets •Driving Privileges Restoration •License Suspension Due to DUI •Repossession	

2022 LEGAL PLAN COMPARISONS

Additional features:	**Telephone advice, office consultations, demand letters and document review** on an unlimited number of personal legal matters.
	For non-covered matters that are not otherwise excluded employees get **four additional hours** of network attorney time and services per plan year.[6]
	Reduced fees for personal injury provided by network attorneys.
	Access to a **digital estate planning solution** for wills, living wills, power of attorney and living trusts.

Regular Full and Part-time Employees (Rates are per pay period)			
	Employee	**Employee + 1**	**Family**
Classic	$ 3.12	$ 3.81	$ 4.79
Premier	$ 5.19	$ 6.23	$ 7.29