2018 SINGLE Plan Options
NIESC

Plan 1 $750 Deductible Max Out-of-Pocket $1,650	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Employee Only Medical	$ 8,352.00	$ 6,900.00	$ 1,452.00	$ 1,452.00	Per Year
				$ 60.50	Per 24 Pays
Employee Only Vision	$ 127.68			$ 127.68	Per Year
				$ 5.32	Per 24 Pays
Family Vision	$ 329.76			$ 329.76	Per Year
				$ 13.74	Per 24 Pays
Employee Only Dental	$ 403.44			$ 403.44	Per Year
				$ 16.81	Per 24 Pays
Family Dental	$ 1,337.52			$ 1,337.52	Per Year
				$ 55.73	Per 24 Pays

Plan 2 $3000 Deductible Max Out-of-Pocket $3,000	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Employee Only Medical	$ 6,672.00	$ 6,900.00	$ (228.00)	$ 1.00	Per Year
You will have $228 total credit available to apply to any of the premiums below					
Employee Only Vision	$ 127.68	Per Year			
Family Vision	$ 329.76	Per Year			
Employee Only Dental	$ 403.44	Per Year			
Family Dental	$ 1,337.52	Per Year			

Plan 3 $6000 Deductible Max Out-of-Pocket $6,000	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Employee Only Medical	$ 5,724.00	$ 6,900.00	$ (1,176.00)	$ 1.00	Per Year
Employee Only Vision	$ 127.68	$ 127.68	$ (1,048.32)	$ 1.00	Per Year
Family Vision	$ 329.76	$ 127.68	$ 202.08	$ 202.08	Per Year
				$ 8.42	Per 24 Pays
Employee Only Dental	$ 403.44	$ 403.44	$ (772.56)	$ 1.00	Per Year
Family Dental	$ 1,337.52	$ 403.44	$ 934.08	$ 934.08	Per Year
				$ 38.92	Per 24 Pays

IF YOU SELECT ALL 3 Employee Only Coverages PPO 3 Medical, Vision & Dental it is only $1.00 per year

2018 FAMILY Plan Options
NIESC

Plan 1 $1500 Deductible Max Out-of-Pocket $3,300	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Medical Family	$ 22,272.00	$ 6,900.00	$ 15,372.00	$ 15,372.00	Per Year
				$ 640.50	Per 24 Pays
Employee Only Vision	$ 127.68			$ 127.68	Per Year
				$ 5.32	Per 24 Pays
Family Vision	$ 329.76			$ 329.76	Per Year
				$ 13.74	Per 24 Pays
Employee Only Dental	$ 403.44			$ 403.44	Per Year
				$ 16.81	Per 24 Pays
Family Dental	$ 1,337.52			$ 1,337.52	Per Year
				$ 55.73	Per 24 Pays

Plan 2 $6000 Deductible Max Out-of-Pocket $6,000	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Medical Family	$ 17,976.00	$ 6,900.00	$ 11,076.00	$ 11,076.00	Per Year
				$ 461.50	Per 24 Pays
Employee Only Vision	$ 127.68			$ 127.68	Per Year
				$ 5.32	Per 24 Pays
Family Vision	$ 329.76			$ 329.76	Per Year
				$ 13.74	Per 24 Pays
Employee Only Dental	$ 403.44			$ 403.44	Per Year
				$ 16.81	Per 24 Pays
Family Dental	$ 1,337.52			$ 1,337.52	Per Year
				$ 55.73	Per 24 Pays

Plan 3 $12000 Deductible Max Out-of-Pocket $12,000	Annual Cost	Corporation Contribution	Difference between Annual Cost & Corp Contribution	Employee Pays	
Medical Family	$ 15,468.00	$ 6,900.00	$ 8,568.00	$ 8,568.00	Per Year
				$ 357.00	Per 24 Pays
Employee Only Vision	$ 127.68			$ 127.68	Per Year
				$ 5.32	Per 24 Pays
Family Vision	$ 329.76			$ 329.76	Per Year
				$ 13.74	Per 24 Pays
Employee Only Dental	$ 403.44			$ 403.44	Per Year
				$ 16.81	Per 24 Pays
Family Dental	$ 1,337.52			$ 1,337.52	Per Year
				$ 55.73	Per 24 Pays