

2027 EMPLOYEE BENEFITS SUMMARY

NON-UNION EMPLOYEES

Medical Plan Details & Premiums

2027 Medical Plan		
	In-Network	Out-of-Network
Calendar Year Deductible	$1,500 Individual; $4,500 Family	$1,500 Individual; $4,500 Family
Coinsurance (amount you pay after deductible)	20%	50%
Out-of-Pocket Maximum	$6,500 Individual; $15,000 Family	$6,500 Individual; $15,000 Family
Preventive Care Services	Covered 100%	50% after deductible
Physician Office Visit	$30 Copay	50% after deductible
Specialist Office Visit	$50 Copay	50% after deductible
Virtual Visit (Teladoc)	$20 copay	n/a
Inpatient Hospital Services	20% after deductible	50% after deductible
Outpatient Hospital Services	20% after deductible	50% after deductible
Urgent Care Visit or Walk-In Clinic	$75 Copay	50% after deductible
Emergency Room Visit	$150 copay, plus 20% after in-network deductible	
Ambulance (ground and air)	20% after in-network deductible	
Chiropractic Visit (unlimited visits)	20% after deductible	50% after deductible
Occupational, Physical, Aquatic, and Speech Therapy (unlimited visits)	20% after deductible	50% after deductible

Enroll in the Total Health Wellness program and reduce your bi-weekly premium. Complete a biometric screening and health assessment to save $11.54/pay period (Tier 1), or add wellness activity points to save $23.08/pay period (Tier 2) — up to $600/year.

2027 Bi-Weekly Medical Premiums - Complete wellness activities through Total Health Wellness to reduce your bi-weekly premium.			
	Health (No Wellness Discount)	Health w/ Tier 1 Reduction	Health w/ Tier 2 Reduction
Employee Only	$91.98	$80.44	$68.90
Employee + Spouse	$247.92	$236.38	$224.84
Employee + Child(ren)	$203.98	$192.44	$180.90
Family	$326.84	$315.30	$303.77

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Dental Plan Details & Premiums

2027 Dental Plan	
Individual/Family Annual Deductible	$50 Individual; $150 Family
Annual Maximum	$1,500/covered person
Preventive Care	No charge
Basic Services	You pay 20% after deductible
Major Services	You pay 50% after deductible
Orthodontic Services	Not covered
Orthodontic Maximum	N/A

2027 Bi-Weekly Dental Premiums	
Employee Only	$13.30
Employee + Spouse	$26.81
Employee + Child(ren)	$24.66
Family	$37.70

Vision Plan Details & Premiums

2027 Vision Plan	
Eye Exam Copay	$20 copay
Single Vision Lenses	$20 copay
Bifocal, Trifocal, Lenticular	$20 copay
Frames Allowance	$130 allowance then 20% off balance
Elective Contacts	Conventional: $130 allowance then 15% off balance | Elective: $130 allowance

2027 Bi-Weekly Vision Premiums	
Employee Only	$2.70
Employee + Spouse	$4.72
Employee + Child(ren)	$5.12
Family	$7.81

New for 2027: Basic Dependent Group Life Coverage

For 2027, you can cover your eligible dependents with Basic Dependent Group Life insurance.

Spouse: $20,000 coverage **Child(ren):** $10,000 coverage

Cost: $0.95 per month ($0.44 per pay period)

Full plan details and plan information can be found by visiting the **MFA Benefits Hub at mymfabenefits.com**, the **MyMFA Intranet**, or reaching out to **Employee Benefits**.

MFA INCORPORATED

Corporate Office

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Phone: (573) 874-5111 ask for "Employee Benefits"

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