Dental Benefits Overview
For the period beginning 1/1/2016

Eligible employees include full-time employees actively working at least 30 hours per week. Employees must be enrolled for dental coverage before it can be offered to their dependents. Eligible dependents include the employee's spouse and children.

Dental Insurance Overview – Principal (http://www.principal.com/**)**

Annual Deductible (Waived for Diagnostic & Preventative Services) Per Member Per Calendar Year Per Family Per Calendar Year	 $50 $150
A – Exams, X-rays and Cleanings	100%
B – Basic Restorative, Basic & Major Endodontics, Basic & Major Periodontics, Basic & Major Oral Surgery	80%
C – Major Restorative, Implants and Prosthodontics	50%
Benefit Maximum Per Calendar Year	$1000 (Part A benefits do not apply)
Child Orthodontic Benefits	$0 deductible, 50% coinsurance up to $1000 max benefit

The following deductions are 'per-pay-period' and include a $10 per month contribution by the bank to each enrolled employee's dental plan.

Payroll Contribution	Current Contribution	Contribution Effective 1/1/2016
Individual	$11.62	$11.62
EE / Spouse	$26.85	$26.85
EE / Child(ren)	$35.91	$35.91
Family	$54.05	$54.05

Please refer to Dental PPO Benefit Summary below for additional information.

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Vision Benefits Overview
For the period beginning 1/1/2016

Eligible employees include full-time employees actively working at least 30 hours per week. Employees must be enrolled for dental coverage before it can be offered to their dependents. Eligible dependents include the employee's spouse and children.

Vision Insurance Overview – Principal (www.vsp.com)

Exams Copay Frames & Lenses Copay	$10 $25
Benefits	In Network / Out of Network
Eye Exam	Covered in Full / Up to $45
Single Vision Lenses	Covered in Full / Up to $30
Lined Bifocal Lenses	Covered in Full / Up to $50
Lined Trifocal Lenses	Covered in Full / Up to $65
Lenticular Lenses	Covered in Full / Up to $100
Frames	Up to $60 Copay Up to $150 Allowance / Up to $70
Contact Lenses - Elective	Up to $150 Allowance / Up to $105
Contact Lenses – Medically Necessary	$25 Copay Covered in Full / Up to $210

The following deductions are 'per-pay-period'

Payroll Contribution	Current Contribution	Contribution Effective 1/1/2016
Individual	$4.25	$4.42
EE / Spouse	$9.16	$9.52
EE / Child(ren)	$7.40	$7.70
Family	$12.31	$12.80

Please refer to Voluntary Vision Benefit Summary below for additional information.

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