Medical, Dental, and Vision Insurance Plan Pricing (Dec 2019- Nov 2020)

MEDICAL	UHC G	
Effective 12/1/2019	**Fully Insured**	
Network	Choice Plus	Choice Plus
Medical Plan Design	1500/100	3000/100
IN- NETWORK	**Plan 1** -1500	**Plan 2** -3000
Deductible Ind/Fam	$1,500/$3,000	$3000/$6000
Co-Insurance	100%	100%
OV Co-pay-PCP/SPEC/UC	$20/$20/$50	$30/$45/$45
Emergency Room Co-pay	$100	$250
Outpatient Surgery	Ded & co-ins	Ded & co-ins
Lab/X-Ray*(Outpatient)	No charge	No Charge
Complex Imaging	Ded & Co-ins	Ded & Co-ins
RX Co-pay	$10/$25/$60	$10/$25/$60
Out- of- pocket Max (inc deduct, RX copays)	$3000/$6000	$5000/$10000
OUT-OF-NETWORK		
Deductible Ind/Fam	$3000/$6,000	$5000/$10000
Co-Insurance	80%	80%
Out- of- pocket Max(inc deduct)	$4500/$9000	$10000/$20000
Rates (Per Pay Period)		
Employee Only	$173.14	$157.54
Employee + Spouse	$380.90	$346.58
Employee + Child(ren)	$328.96	$299.32
Family	$536.72	$488.37

DENTAL	UHC G
Network	**Passive PPO**
Dental Plan Design	National PPO 30
Benefit Overview	
Deductible Ind(I/O)/ Fam(I/O)	$50/$50 $150/$150
Co-Insurance:	
Preventive & Diagnostic(I/O)	100%/100%
Minor Restorative(I/O)	50%/50%
Endodontic/Periodic/Oral Surgery(I/O)	50%/50%
Major (I/O)	50%/50%
Waiting Period:	
Major	None
Annual Maximum(I/O)	$1000/$1000
Rates (Per Pay Period)	
Employee	$11.36
Employee + Spouse	$22.72
Employee + Child(ren)	$25.53
Employee + Family	$38.78

VISION	UHC G
Network	**Voluntary**
Vision Plan Design	Vision Plan B
Benefit Overview/Frequency	
Exam	12 months
Lenses	12 months
Frames	24 months
In network Copays	
Exam	$10
Single vision Lenses	$25
Frames	$130 allowance
Contact Lenses	covered in full up to 4 boxes after $25 copay
Out of network allowance	
Exam	$40 reimbursement
Single vision Lenses	$40 reimbursement
Frames	$45 reimbursement
Contact Lenses	$105 reimbursement
Rates (Per Pay Period)	
Employee	$2.93
Employee + Spouse	$5.56
Employee + Child(ren)	$6.49
Employee + Family	$9.16