

Health Insurance from United Healthcare BASE PLAN (Doctors Plan Network)		
Plan Summary <i>*Please see full plan description for full benefits</i>		
Plan Series	Health Savings Account	
Plan Name	Plan BJTF	Full Cost
Network	Choice	Employee Only \$819.89
Need a referral?	Yes	Employee + Spouse \$1,721.76
Out-of-Network Benefits?	No	Employee + Child(ren) \$1,410.22
Office Visit	\$0 primary/\$100 specialist	Employee + Family \$2,484.26
Prescriptions	\$10/\$35/\$60/\$100	
Deductible - Individual	\$6,000	Employee Monthly Cost
Deductible - Family	\$12,000	Employee Only \$409.95
Coinsurance Rate (after deductible)	20%	Employee + Spouse \$1,311.82
Out-of-Pocket limit - Individual	\$7,350	Employee + Child(ren) \$1,000.28
Out-of-Pocket Limit - Family	\$14,700	Employee + Family \$2,074.32
Hospital Inpatient	Deductible & Coinsurance	
Outpatient	Deductible & Coinsurance	
Emergency Room	\$500 + Deductible & Coinsurance	
Urgent Care	\$0	
Lab & X-ray	\$25	
MRI, CT, PET Scan	\$500	
Mental Health	\$0	
Physical Therapy	Deductible & Coinsurance	
If your insurance costs for single coverage on the BASE plan exceed 9.61% of your average monthly salary, you may be entitled to further assistance from Alpine Homecare on the premium cost.		
BUY UP PLAN OPTION (Choice Plus Network)		
Plan Summary <i>*Please see full plan description for full benefits</i>		
Plan Series	Health Savings Account	
Plan Name	Plan AQ50	Full Cost
Network	Choice Plus	Employee Only \$881.55
Need a referral?	No	Employee + Spouse \$1,851.26
Out-of-Network Benefits?	Yes	Employee + Child(ren) \$1,516.27
Office Visit	Deductible	Employee + Family \$2,671.08
Prescriptions	Deductible	
Deductible - Individual	\$6,000 (embedded)	Employee Monthly Cost
Deductible - Family	\$12,000	Employee Only \$471.61
Coinsurance Rate (after deductible)	0%	Employee + Spouse \$1,441.32
Out-of-Pocket limit - Individual	\$6,000	Employee + Child(ren) \$1,106.33
Out-of-Pocket Limit - Family	\$12,000	Employee + Family \$2,261.14
Hospital Inpatient	Deductible	
Outpatient	Deductible	
Emergency Room	Deductible	
Urgent Care	Deductible	
Lab & X-ray	Deductible	
MRI, CT, PET Scan	Deductible	
Mental Health	Deductible	
Physical Therapy	Deductible	
H.S.A. Deduction Type and Contributions for Tax Year 2022		
HSA annual contributions limits		Individual coverage – \$3,650 Family Coverage - \$7,300
HSA catch-up contributions		\$1,000 for an accountholder age 55+

Dental Plan - United Healthcare Plan B8615

Network	Options PPO 20	Employee Monthly Cost	
Provider Search	www.myuhc.com	Employee Only	\$23.81
Deductible	\$50/individual/\$150 per family	Employee + Spouse	\$47.62
Annual Plan Maximum	\$1,000	Employee + Child(ren)	\$52.50
Preventive Services	100%	Employee + Family	\$80.13
Basic Dental Services (fillings, etc.)	80% after deductible		
Endodontics/Periodontics/Oral Surgery	50% after deductible		
Major Services (crowns, bridges, dentures)	50% after deductible		

Vision Plan - United Healthcare Plan S1008

Exam Frequency	Every 12 months	Employee Monthly Cost	
Lens Frequency (eyeglasses or contacts)	Every 12 months	Employee Only	\$4.61
Frames Frequency	Every 24 months	Employee + Spouse	\$8.75
Copay for Exam	\$10	Employee + Child(ren)	\$10.26
Copay for Materials	\$25	Employee + Family	\$14.44
Copay for Retinal Screening for Diabetics	\$0		
Contact Lens Allowance	\$105		
Contact Lens Fitting Allowance	\$30		
Retail Frame Allowance	\$130 (plus 30% discount at participating providers)		
Covered Lens Options	Std Scratch Coating, Polycarb to age 19		