Health Insurance from United Healthcare
BASE PLAN (Doctors Plan Network)

	Plan Summary *Please see full plan description for full benefits*
Plan Series	Health Savings Account
Plan Name	Plan CY7U
Network	**Doctors Plan**
Need a referral?	No
Out-of-Network Benefits?	No
Office Visit	$0/$100
Prescriptions	$5/$40/$105/$250, Speciality $500
Deductible - Individual	$6,000 (embedded)
Deductible - Family	$12,000
Coinsurance Rate (after deductible)	20%
Out-of-Pocket limit - Individual	$7,350
Out-of-Pocket Limit - Family	$14,700
Hospital Inpatient	Covered at 80% after deductible
Outpatient	Covered at 80% after deductible
Emergency Room	$500, then covered at 80% after deductible
Urgent Care	No charge
Lab & X-ray	$25 Copay per Service
MRI, CT, PET Scan	Covered at 80% after deductible
Mental Health	No charge
Physical Therapy	Covered at 80% after deductible

Full Cost	
Employee Only	$987.30
Employee + Spouse	$2,073.32
Employee + Child(ren)	$1,698.17
Employee + Family	$2,991.51

Employee Monthly Cost	
Employee Only	$493.65
Employee + Spouse	$1,579.67
Employee + Child(ren)	$1,204.52
Employee + Family	$2,497.86

If your insurance costs for single coverage on the BASE plan exceed 8.39% 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 *Please see full plan description for full benefits*
Plan Series	Choice Plus
Plan Name	Plan DDS6
Network	**Choice Plus**
Need a referral?	No
Out-of-Network Benefits?	No
Office Visit (primary care/specialist)	Deductible
Prescriptions	Deductible
Deductible - Individual	$6,000 (embedded)
Deductible - Family	$12,000
Coinsurance Rate (after deductible)	0%
Out-of-Pocket limit - Individual	$6,000
Out-of-Pocket Limit - Family	$12,000
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 (20 visits)	Deductible

Full Cost	
Employee Only	$1,100.09
Employee + Spouse	$2,310.20
Employee + Child(ren)	$1,892.16
Employee + Family	$3,333.25

Employee Monthly Cost	
Employee Only	$606.44
Employee + Spouse	$1,816.55
Employee + Child(ren)	$1,398.51
Employee + Family	$2,839.60

H.S.A. Deduction Type and Contributions for Tax Year 2024	
HSA annual contributions limits	Individual coverage – $4,150 Family Coverage - $8,300
HSA catch-up contributions	$1,000 for an accountholder age 55+

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Dental Plan - United Healthcare Plan B8615			
Network	Options PPO 20	**Employee Monthly Cost**	
Provider Search	www.myuhc.com	Employee Only	$29.28
Deductible	$50/individual/$150 per family	Employee + Spouse	$58.55
Annual Plan Maximum	$1,000	Employee + Child(ren)	$64.55
Preventive Services	100%	Employee + Family	$98.53
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		

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