MEDICAL BENEFITS

	UHC Select Plus PPO HRA 5000 (CQG2)		UHC Select Plus Classic PPO 1000 (CUJB)		UHC Select Plus Premier PPO 500 (CUI4)	
Benefits	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited	
HRA Funding(individual)	Yes		N/A		N/A	
HRA Funding (family)	Yes		N/A		N/A	
Deductible						
- Individual	$5,000	$10,000	$1,000	$3,000	$500	$1,500
- Family	$10,000	$20,000	$2,000	$6,000	$1,000	$3,000
Out of Pocket Maximum	Includes Deductible		Includes Deductible		Includes Deductible	
- Individual	$7,150	$20,000	$5,000	$15,000	$3,500	$10,500
- Family	$14,300	$40,000	$10,000	$30,000	$7,000	$21,000
Coinsurance	20%	50%	20%	50%	20%	50%
Preventive Services/ Well Baby Care	No Charge	Not covered	No Charge	Not covered	No Charge	Not covered
Office Visit (Primary/Specialist)	$35 / $70	Ded + 50%	$25 / $50	Ded + 50%	$15 / $30	Ded + 50%
Urgent Care	$50	Ded + 50%	$50 Copay	Ded + 50%	$50	Ded + 50%
Lab and X-Ray	Ded + 20%	Lab testing: not covered / X-Ray: Ded + 50%	Ded + 20%	Lab testing: not covered / X-Ray: Ded + 50%	Ded + 20%	Lab testing: not covered / X-Ray: Ded + 50%
MRI/CT/PET	Ded + 20%	Ded + 50%	Ded + 20%	Ded + 50%	Ded + 20%	Ded + 50%
Hospitalization	$350 then Ded + 20%	$350 then Ded + 50%	Ded + 20%	Ded + 50%	Ded + 20%	Ded + 50%
Outpatient Surgery (surgical center or physician office)	Ded + 20%	Ded + 50%	Ded + 20%	Ded + 50%	Ded + 20%	Ded + 50%
Emergency Room	$350 (waived if admitted) then Ded + 20%		Ded + 20%		Ded + 20%	
Acupuncture (20 per year)	$35	Not covered	$25	Not covered	$15	Ded + 50%
Chiropractic Services (24 per year)	$35	Ded + 50%	$25	Ded + 50%	$15	Ded + 50%
Mental Health Outpatient	$35	Ded + 50%	$25	Ded + 50%	$15	Ded + 50%
Prescriptions (retail)						
- Rx Deductible	None		None		Subject to Medical Ded.	
- Tier 1 (generic)	$10	$10	$10	$10	$10	$10
- Tier 2 (higher priced generic & lower priced brand)	$35	$35	$35	$35	$35	$35
- Tier 3 (higher priced brand)	$70	$70	$60	$60	$60	$60
EMPLOYEE CONTRIBUTION	MONTHLY		MONTHLY		MONTHLY	
TIME WORKED	**<1 year**	**>1 year**	**<1 year**	**>1 year**	**<1 year**	**>1 year**
Employee Only	$212.18	$212.18	$492.35	$492.35	$555.59	$555.59
Employee & Spouse	$1,186.37	$886.37	$1,802.57	$1,502.57	$1,941.68	$1,641.68
Employee & Child(ren)	$861.96	$561.96	$1,366.28	$1,066.28	$1,480.12	$1,180.12
Family	$1,917.79	$1,617.79	$2,786.33	$2,486.33	$2,982.38	$2,682.38

EMPLOYER CONTRIBUTION	HRA EMPLOYER MONTHLY FUNDFING	
Employee Only	$208.33	$208.33
Employee & Spouse	$416.67	$416.67
Employee & Child(ren)	$416.67	$416.67
Family	$416.67	$416.67

The benefits illustrated above are meant to serve as a summary of the benefits available under the carrier's plan. Should any discrepancy arise, the carrier's documents supersede this illustration. Once enrolled, you will receive a Combined Evidence of Coverage and Disclosure Form that explains the exclusions and limitations, as well as the full range of covered services of your plan, in detail.

MEDICAL BENEFITS

	UHC Select Plus PPO HSA 3400 (EBKK)	
Benefits	In Network	Out of Network
Lifetime Maximum Benefit	Unlimited	
Deductible		
- Individual	$3,400	$9,000
- Family	$6,800	$18,000
Out of Pocket Maximum	Includes Deductible	
- Individual	$6,000	$18,000
- Family	$12,000	$36,000
Coinsurance	10%	50%
Preventive Services/ Well Baby Care	No Charge	Not covered
Office Visit (Primary/Specialist)	Ded + 10%	Ded + 50%
Urgent Care	Ded + 10%	Ded + 50%
Lab and X-Ray	Ded + 10%	Lab testing: not covered / X-Ray: Ded + 50%
MRI/CT/PET	Ded + 10%	Ded + 50%
Hospitalization	$350 then Ded + 10%	$350 then Ded + 50%
Outpatient Surgery (surgical center or physician office)	Ded + 10%	Ded + 50%
Emergency Room	Ded + 10%	
Acupuncture (20 per year)	Ded + 10%	Not covered
Chiropractic Services (24 per year)	Ded + 10%	Ded + 50%
Mental Health Outpatient	Ded + 10%	Ded + 50%
Prescriptions (retail)		
- Rx Deductible*	None	
- Tier 1 (generic)	$10	$10
- Tier 2 (higher priced generic & lower priced brand)	$35	$35
- Tier 3 (higher priced brand)	$70	$70
EMPLOYEE CONTRIBUTION	MONTHLY	
TIME WORKED	**<1 year**	**>1 year**
Employee Only	$299.93	$299.93
Employee & Spouse	$1,259.42	$1,059.42
Employee & Child(ren)	$939.92	$739.92
Family	$1,979.82	$1,779.82

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MEDICAL BENEFITS

	Kaiser Permanente Traditional HMO 15		Kaiser Permanente DHMO 1500	
Benefits	In Network		In Network	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Deductible				
- Individual	None		$1,500	
- Family	None		$3,000	
Out of Pocket Maximum				
- Individual	$1,500		$4,000	
- Family	$3,000		$8,000	
Coinsurance	N/A		30%	
Office Visit (primary/specialist)	$15 / $15		$40 / $50	
Urgent Care	$15 copay		$40 copay	
Preventive Services/ Well Baby Care	No charge		No charge	
Lab and X-Ray	No charge		$15 copay	
MRI/CT/PET	No charge		30% after ded	
Hospitalization	$250 per admission		30% after ded	
Outpatient Surgery	$15 per procedure		30% after ded	
Emergency Room	$100 copay		30% after ded	
Acupuncture	$15 copay		Not covered	
Chiropractic Services	Not covered		Not covered	
Prescriptions				
- Rx Deductible	None		None	
- Generic	$10 copay		$10	
- Brand	$25 copay		$30	
- Non-formulary	$25 copay		20% up to $250	
EMPLOYEE CONTRIBUTION PER MONTH	**MONTHLY (<1 year)**	**MONTHLY (>1 year)**	**MONTHLY (<1 year)**	**MONTHLY (>1 year)**
Employee Only	$505.67	$505.67	$276.80	$276.80
Employee & Spouse	$1,832.47	$1,532.47	$1,328.96	$1,028.96
Employee & Child(ren)	$1,611.34	$1,311.34	$1,153.60	$853.60
Family	$2,717.00	$2,417.00	$2,030.4	$1,730.40

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DENTAL, VISION, LIFE, & DISABILITY BENEFITS

DENTAL	United Healthcare	
	In Network	Out Of Network
Annual Max	$1,500	
Orthodontia Lifetime Max	not covered	
Deductible		
Preventive	$0	
Basic (Individual/Family)	$50/$150	$50/$150
Major (Individual/Family)	$50/$150	$50/$150
Coinsurance		
Preventive	100%	
Basic	80%	80%
Major	50%	50%
Orthodontia	not covered	
Important Provisions		
Endodontic Services	basic	
Periodontal Maintenance	basic	
Periodontal Surgery	basic	
Oral Surgery (Simple Extractions)	basic	
Oral Surgery (Complex Extractions)	basic	
Usual & Customary	negotiated fee	90th percentile
EMPLOYEE CONTRIBUTION PER MONTH	**FULL PLAN DESCRIPTION**	
Employee only	$0	
Employee + spouse	$53.19	
Employee + child/ren	$83.06	
Employee + family	$144.70	

VISION	United Healthcare	
	in network	out of network
Office visit copay	$10	n/a
Materials copay	$25	n/a
Eye exam reimbursement	100%	up to $40
Lenses		
Single vision	covered after copay	up to $40
Bifocal	covered after copay	up to $60
Trifocal	covered after copay	up to $80
Contact lenses	$130	up to $105
Frames allowance	$130 + 30%	up to $45
Eye exam	every 12 months	
Lenses	every 12 months	
Contact lenses	every 12 months	
Frames	every 24 months	
EMPLOYEE CONTRIBUTION PER MONTH	**FULL PLAN DESCRIPTION**	
Employee only	$0	
Employee + spouse	$4.74	
Employee + child/ren	$5.42	
Employee + family	$11.50	

BASIC LIFE	United Healthcare
Class	All Eligible Employees
Benefit Amount	$50,000
AD&D Benefit	Same as Benefit Amount
Guaranteed Issue	$50,000
	PLAN DETAILS

OPTIONAL LIFE	United Healthcare
Class	All Eligible Employees
Benefit Amount	$10,000 increments;
	5X salary up to $500,000
Employee AD&D Benefit	Same as Benefit Amount
Guaranteed Issue (EE/SP/CH)	$100,000 / $30,000 / $15,000
Spouse Life Benefit	$5,000 increments up to $250,000
	not to exceed 50% of EE benefit
Child Life Benefit	$5,000 increments up to $15,000
	PLAN DETAILS

SHORT-TERM DISABILITY	United Healthcare
Class	All Eligible Employees
Taxable Benefit	Yes
Benefit Percentage	60%
Benefit Maximum	$2,500/wk
Elimination Period	
Accident	7 Days
Sickness	7 Days
Benefit Duration	12 Weeks
	PLAN DETAILS

LONG-TERM DISABILITY	United Healthcare
Class	All Eligible Employees
Taxable Benefit	Yes
Benefit Percentage	60%
Benefit Maximum	$10,800/mo
Guaranteed Issue	$10,800
Elimination Period	90 Days
Benefit Duration	SSNRA
Own Occupation	2 Years
Pre-Existing	3/12
	PLAN DETAILS