

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 \$741.66
Need a referral?	Yes	Employee + Spouse \$1,557.48
Out-of-Network Benefits?	No	Employee + Child(ren) \$1,275.66
Office Visit	\$0 primary/\$100 specialist	Employee + Family \$2,247.22
Prescriptions	\$10/\$35/\$60/\$100	
Deductible - Individual	\$6,000	Employee Monthly Cost
Deductible - Family	\$12,000	Employee Only \$370.83
Coinsurance Rate (after deductible)	20%	Employee + Spouse \$1,186.65
Out-of-Pocket limit - Individual	\$7,350	Employee + Child(ren) \$904.83
Out-of-Pocket Limit - Family	\$14,700	Employee + Family \$1,876.39
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 9.83% 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 \$805.08
Need a referral?	No	Employee + Spouse \$1,690.67
Out-of-Network Benefits?	Yes	Employee + Child(ren) \$1,384.74
Office Visit	Deductible	Employee + Family \$2,439.38
Prescriptions	Deductible	
Deductible - Individual	\$6,000 (embedded)	Employee Monthly Cost
Deductible - Family	\$12,000	Employee Only \$434.25
Coinsurance Rate (after deductible)	0%	Employee + Spouse \$1,319.84
Out-of-Pocket limit - Individual	\$6,000	Employee + Child(ren) \$1,013.91
Out-of-Pocket Limit - Family	\$12,000	Employee + Family \$2,068.55
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 2021		
HSA annual contributions limits		Individual coverage – \$3,600 Family Coverage - \$7,200
HSA catch-up contributions		\$1,000 for an accountholder age 55+

Dental Plan - United Healthcare Plan B8615		
Network	Options PPO 20	Employee Monthly Cost Employee Only \$23.84 Employee + Spouse \$47.69 Employee + Child(ren) \$52.58 Employee + Family \$80.25
Provider Search	www.myuhc.com	
Deductible	\$50 individual/\$150 per family	
Annual Plan Maximum	\$1,000	
Preventive Services	100%	
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 Employee Only \$4.61 Employee + Spouse \$8.75 Employee + Child(ren) \$10.26 Employee + Family \$14.44
Lenses Frequency (eyeglasses or contacts)	Every 12 months	
Frames Frequency	Every 24 months	
Copay for Exam	\$10	
Copay for Materials	\$25	
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	