



Medical Benefits Summary	Option 1			Option 2			Option 3		
Plan Name	Basic Plan			Standard Plan			Premier Plan		
Product/Network	Aetna Signature Administrators			Aetna Signature Administrators			Aetna Signature Administrators		
	Network			Network			Network	Non-Network	
Annual Benefit Maximum	Unlimited			Unlimited			Unlimited		
Single Deductible Amount	\$2,500			\$1,500			\$750	\$1,500	
Family Deductible Amount	\$5,000			\$3,000			\$1,500	\$3,000	
Plan Coinsurance %	70%			75%			80%	50%	
Single Out of Pocket <i>(excludes deductible)</i>	\$3,000			\$2,500			\$1,500	\$3,000	
Family Out of Pocket <i>(excludes deductible)</i>	\$6,000			\$5,000			\$3,000	\$6,000	
Telemedicine (Teledoc)	100%			100%			100%	Not Covered	
Office Visit (PCP)	\$25 then 100%			\$25 then 100%			\$25 then 100%	50% after Ded	
Office Visit (Specialist)	\$40 then 100%			\$40 then 100%			\$40 then 100%	50% after Ded	
Urgent Care Visit	\$50 then 100%			50% after Ded			\$50 then 100%		
ER Visit	\$200 then 100%			\$200 then 100%			\$200 then 100%		
Chiropractic Visit	\$40 then 100%			\$40 then 100%			\$40 then 100%	50% after Ded	
Hospital Charges (Inpatient)	70% after Ded			75% after Ded			80% after Ded	50% after Ded	
Room and Board	70% after Ded			75% after Ded			80% after Ded	50% after Ded	
Surgery (Inpatient or Outpatient)	70% after Ded			75% after Ded			80% after Ded	50% after Ded	
Ambulance	70% after Ded			75% after Ded			80% after Ded	50% after Ded	
Speech, Occupational and Physical Therapy	70% after Ded			75% after Ded			80% after Ded	50% after Ded	
Preventative/Routine Tests	100%			100%			100%	50% after Ded	
	Prescription Drug			Prescription Drug			Prescription Drug		
Retail – Generic	\$10			\$10			\$10		
Retail – Formulary	25% (\$25 Minimum; \$50 Maximum)			25% (\$25 Minimum; \$50 Maximum)			25% (\$25 Minimum; \$50 Maximum)		
Retail – Non-Formulary	50% (\$50 Minimum; \$100 Maximum)			50% (\$50 Minimum; \$100 Maximum)			50% (\$50 Minimum; \$100 Maximum)		
Retail – Specialty	50% (\$150 Maximum)			50% (\$150 Maximum)			50% (\$150 Maximum)		
Mail Order – Generic	\$25			\$25			\$25		
Mail Order – Formulary	25%(\$62.50 Minimum; \$125 Maximum)			25%(\$62.50 Minimum; \$125 Maximum)			25%(\$62.50 Minimum; \$125 Maximum)		
Mail Order – Non-Formulary	50%(\$125 Minimum; \$250 Maximum)			50%(\$125 Minimum; \$250 Maximum)			50%(\$125 Minimum; \$250 Maximum)		
Tier A \$11.50 Per Hour or Less/Tier B \$11.51 to \$16.00 Per Hour/Tier C \$16.01 Per Hour or Higher									
Cost Per Pay*	Tier A	Tier B	Tier C	Tier A	Tier B	Tier C	Tier A	Tier B	Tier C
Employee Only	\$37.16	\$53.89	\$74.81	\$76.93	\$93.66	\$114.58	\$127.16	\$143.89	\$164.81
Employee and Spouse	\$94.42	\$131.22	\$177.22	\$182.21	\$219.02	\$265.02	\$292.93	\$329.73	\$375.73
Employee and Child	\$62.70	\$95.32	\$136.10	\$140.49	\$173.11	\$213.89	\$238.59	\$271.22	\$311.99
Employee and Children	\$62.70	\$95.32	\$136.10	\$140.49	\$173.11	\$213.89	\$238.59	\$271.22	\$311.99
Employee and Family	\$136.62	\$199.68	\$278.51	\$287.25	\$350.31	\$429.14	\$477.09	\$540.15	\$618.98

*Cost per pay will be reduced by \$10 per week for participation in the biometric screening.

**Cost per pay will be reduced by \$15 per week if health scores are met.

- 1) Benefits will be determined based on CoreSource's medical and administrative policies and procedures.
- 2) This document is only a partial listing of benefits. This is not a contract of insurance.
- 3) The contract or certificate will contain the complete listing of covered services. Also, the certificate will include any type of visit limitations.
- 4) This document is for illustrative purposes only and not a guarantee of coverage.
- 5) Basic and Standard Plans no longer offer non-network benefits.

2020 Dental Plan Summary

Deductible (individual/family)	\$50/\$100
Preventive Services – Cleanings, X-rays	100% (no deductible)
Essential Services – fillings	80% after deductible
Complex Services – crowns, bridges, dentures	50% after deductible
Benefit Period Max	\$1,500 per member
Orthodontic Services	50%
Orthodontic Lifetime Max (per eligible dependent up to age 19)	\$1,500
Enrollment Level	Cost Per Pay
Employee Only	\$4.44
Employee and Spouse	\$7.64
Employee and Child(ren)	\$9.60
Employee and Family	\$14.40

2020 Vision Plan Summary

Benefit – Every Calendar Year	Coverage with a VSP Doctor
Exam (Not including contact lens exam)	\$0 copay
Prescription Glasses	\$20 copay
Frame	\$130 allowance, 20% off amount over allowance
Lenses	Single vision, lined bifocal, lined trifocal
Lens Options	\$0-\$160 copay
Contacts (instead of glasses)	Up to \$60 copay for fitting exam \$120 allowance (copay does not apply), 15% off contact lens exam (fitting and evaluation)
Enrollment Level	Cost Per Pay w/UCH Medical
Employee Only	\$5.99
Employee and One Person	\$8.56
Employee and Family	\$13.35
Enrollment Level	Cost Per Pay – No UCH Medical
Employee Only	\$6.81
Employee and One Person	\$9.75
Employee and Family	\$15.20