Effective 01/01/2021
United Church Homes
Group Number UH

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
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited
Single Deductible Amount	$2,500	$1,500	$750
Family Deductible Amount	$5,000	$3,000	$1,500
Plan Coinsurance %	70%	75%	80%
Single Out of Pocket *(excludes deductible)*	$3,000	$2,500	$1,500
Family Out of Pocket *(excludes deductible)*	$6,000	$5,000	$3,000
Telemedicine(Teledoc)	100%	100%	100%
Office Visit (PCP)	$25 then 100%	$25 then 100%	$25 then 100%
Office Visit (Specialist)	$40 then 100%	$40 then 100%	$40 then 100%
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%
Hospital Charges (Inpatient)	70% after Ded	75% after Ded	80% after Ded
Room and Board	70% after Ded	75% after Ded	80% after Ded
Surgery (Inpatient or Outpatient)	70% after Ded	75% after Ded	80% after Ded
Ambulance	70% after Ded	75% after Ded	80% after Ded
Speech, Occupational and Physical Therapy	70% after Ded	75% after Ded	80% after Ded
Preventative/Routine Tests	100%	100%	100%
	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	$38.25	$55.65	$77.40	$79.61	$97.01	$118.76	$131.85	$149.25	$171.00
Employee and Spouse	$96.79	$135.07	$182.91	$188.10	$226.38	$274.22	$303.24	$341.52	$389.36
Employee and Child	$64.81	$98.73	$141.14	$145.71	$179.63	$222.04	$247.74	$281.66	$324.07
Employee and Children	$64.81	$98.73	$141.14	$145.71	$179.63	$222.04	$247.74	$281.66	$324.07
Employee and Family	$140.68	$206.26	$288.25	$297.34	$362.93	$444.91	$494.77	$560.36	$642.34

*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 you compete your healthy challenges.

1) Benefits will be determined based on Trustmark'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) All plans have removed out of network services. Emergency Exceptions will be considered.

2021 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)	$2,000
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

2021 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