This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage(COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

MEDICAL BENEFITS				
	MEC	ACA	SILVER	GOLD
Calendar Year Deductible (CYD)	N / A	N/A	$7,000	$4,000
Coinsurance (you pay after CYD)	N / A	N/A	40%	20%
Out of Pocket Maximum (Includes CYD, Copay, Coinsurance)	$1,850	$7,350	$7,350	$7,000
Provider Network	BCBS	BCBS	BCBS	BCBS
Office Visit - Primary Care Physician	$15	$25 / Max 8 Visits	40% After CYD	$25
Office Visit - Specialist	$15	$50 / Max 8 Visits	40% After CYD	$50
Urgent Care Visit	$50	$50 /Max 2 Visits	40% After CYD	$40
Emergency Room	Not Covered	$350 / Max 1 Visit	40% After CYD	$750
Inpatient Hospitalization	Not Covered	$350 / Max 5 Days	40% After CYD	20% After CYD
Outpatient Surgery	Not Covered	$350 / Max 1 Surgery	40% After CYD	20% After CYD
Outpatient Lab Services	$50	$50 / Max 3 Visits	40% After CYD	20% After CYD

Rx Benefits				
	No Deductible	No Deductible	Subject to Deductible	Subject to Deductible
Generic	$15	20%	$15	$10 (Ded. Waived)
Preferred Brand	Not Covered	20%	$45	$40
Non-Preferred Brand	Not Covered	N/A	$80	$85

*Please Note: The MEC Plan does NOT provide major medical coverage. It does provide coverage for services such as Physician Office Consultations, Basic Lab Work/Radiology, Urgent Care Center Visits and some Generic Prescription Drugs. It does NOT cover hospitalization, surgery, mental/nervous or alcohol/substanceabuse services, ambulance, ER, and other services.

Benefits shows above are In-Network. Out of network services are not covered.

Premiums per Paycheck				
Employee Only	$30.00	Varies by Rate of Pay	$201.35	$265.04
Employee + Spouse	$85.38	Varies by Rate of Pay	$756.12	$916.27
Employee + Children	$92.31	Varies by Rate of Pay	$571.04	$699.35
Family	$126.92	Varies by Rate of Pay	$1,126.27	$1,350.58

Dental Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevant information employees need to know about their plan.

	UnitedHealthcare High Option 14P11/U90		UnitedHealthcare Middle Option 14P10/MAC		UnitedHealthcare Low Option 14P12/MAC	
Deductible	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Single	$50	$50	$50	$50	$50	$50
Family	$150	$150	$150	$150	$150	$150
Maximum the carrier will pay						
Annual Maximum	$1,800 per person per Calendar Year	$1,800 per person per Calendar Year	$1,200 per person per Calendar Year	$1,200 per person per Calendar Year	$1,000 per person per Calendar Year	$1,000 per person per Calendar Year
Frequencies						
Cleaning	Limited to 2 times per consecutive 12 months.		Limited to 2 times per consecutive 12 months.		Limited to 2 times per consecutive 12 months.	
Exam	PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.		PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.		PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.	
Dental Coverage						
Cleanings	100%	90%	100%	100%	100%	100%
Exams	100%	90%	100%	100%	100%	100%
X-Rays	100%	90%	100%	100%	100%	100%
Sealants	80%	70%	80%	80%	50%	50%
Fillings	80%	70%	80%	80%	50%	50%
Simple Extractions	80%	70%	80%	80%	50%	50%
Root Canal	80%	70%	80%	80%	50%	50%
Periodontal Gum Disease	80%	70%	Split Class	Split Class	50%	50%
Oral Surgery	80%	70%	80%	80%	50%	50%
Crowns	50%	50%	50%	50%	Not Covered	Not Covered
Dentures	50%	50%	50%	50%	Not Covered	Not Covered
Bridges	50%	50%	50%	50%	Not Covered	Not Covered
Implants	50%	50%	50%	50%	Not Covered	Not Covered
Orthodontia	50%	50%	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia Lifetime Maximum	$1,000 per person per Lifetime		Not Covered		Not Covered	
Orthodontia Maximum Age	Child Only (Up to Age 19)		Not Covered		Not Covered	
Out of Network Explanation						
Out of network dentists are NOT contracted with your dental insurance carrier. After you pay for the service based on your benefit plan, the insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist. In most cases, the out of network dentist does not consider this as payment in full (like an in-network dentist would) and may "Balance bill" you. That is, they may ask you to pay the difference.						
Plan Information						
Waiting Period for Major Services	None		12 months Major		Not Covered	
Plan Year	January 1 - December 31st		January 1 - December 31st		January 1-December 31st	
Network Type	Options PPO		PPO		PPO	
Network Name	UnitedHealthcare Dental Options PPO Plan		Options PPO		Options PPO	
Member Website	www.myuhcdental.com		www.myuhcdental.com		www.myuhcdental.com	
Customer Service Phone Number						

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Premiums are per paycheck

Employee Only	$26.14	$17.92	$9.60
Family	$44.46	$35.31	$18.91

UnitedHealthcare

Vision Benefit

Vision Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevent information employees need to know about their plan.

Vision Coverage	In-Network	Out of Network
Eye Exam	$ 10.00	Up to $40.00
Single Vision Lens	$ 25.00	Up to $40.00
Lined Bi-Focal Lens	$ 25.00	Up to $60.00
Lined Tri-Focal Lens	$ 25.00	Up to $80.00
Contact Lens Allowance	$130.00	Up to $130.00
Frame Allowance	$130.00	Up to $45.00
Frequencies		
Exam Frequency	Once every 12 months	
Lens Frequency	Once every 12 months	
Frame Frequency	Once every 24 months	
Out of Network Explanation		
While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you. You may have to file the claim yourself		
Plan Information		
Plan Year	January 1-December 31st	
Network Name	Powered by Spectera Eyecare Networks	
Member Website	www.myuhcvision.com	

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Premiums are per paycheck

Employee Only	$3.44
Employee + Spouse	$6.52
Employee + Child(ren)	$7.65
Family	$10.77