COMMUNITY CONNECTIONS HEALTHCARE COVERAGE

ELIGIBILITY: Employees working 130+ hours in a month and their dependents. Dependents may enroll in one or all of the coverages that the employee is enrolled in.
ORIENTATION & WAITING PERIOD: 1st of month after 30 days from date of employment.
ENROLLMENT: Regular, benefited employees will be contacted prior to their eligibility date to complete paperwork, even if they will be declining coverage. Employees, not classified as benefited, who work 130+ hours in a month will be contacted immediately upon knowledge of eligibility and offered retroactive coverage for that month.
BREAK IN SERVICE: If you fall below 130 hours in a month, coverage will be terminated for the following month. Once you work 130+ hours you may elect to enroll in coverage for the following month.

	COVERED	PPO	HSA	Dental Vision
EMPLOYEE COST	Employee Only	$0.00	$0.00	$0.00
	Employee & Spouse	$425.00	$250.00	$20.00
	Employee & Child(ren)	$385.00	$245.00	$30.00
	Employee & Family	$775.00	$440.00	$90.00

EMPLOYEE COST DIVIDED BETWEEN THE FIRST AND SECOND PAYROLLS OF EACH MONTH.

NEW HIRE ELIGIBILITY EXAMPLE	Hire Date	30 Days	Benefit Start Date
	October 5	November 5	December 1

PPO

COVERAGE	**Deductible** Annual amount that you will pay before your health insurance begins coverage.	Individual: $500 Family: $1,000
	Preventive Services	100%
	Coinsurance The percentage of your healthcare costs that insurance will cover after your costs exceed your annual deductible. You pay coinsurance for care after you meet your deductible.	Insurance covers 50% after deductible
	Out of Pocket Max This is the maximum total expense that you could incur in a given year.	Individual: $5,500 Family: $11,000
	Pharmacy Copay The fee you pay for each prescription. You pay copay and coinsurance. Does not apply towards satisfying deductible.	Generic: $15 Copay, then insurance covers 100% Preferred: $45 Copay, then insurance covers 100% Non-Preferred: $60 Copay, then insurance covers 100% Preventive Drugs: $0 Copay

HSA

COVERAGE	**Deductible** Annual amount that you will pay before your health insurance begins coverage.	Individual: $3,500 Family: $7,000
	Preventive Services	100%
	Coinsurance The percentage of your healthcare costs insurance will cover after your costs exceed your annual deductible. You pay coinsurance for care after you meet your deductible.	Insurance covers 100% after deductible
	Out of Pocket Max This is the maximum total expense that you could incur in a given year.	Individual: $3,500 Family: $7,000
	Pharmacy Copay The fee you pay for each prescription. You pay for all prescriptions until you meet your deductible. Costs go towards satisfying deductible.	100% after deductible
	Additional Plan Features An employee-owned savings account will be opened with **Avidia Bank** for establishing your HSA by HR personnel. You will receive an email from PBS/Avidia bank to register for your online access. The HSA is portable and funds roll over from year to year. Employees will receive a total monthly **employer contribution of $200**, deposited into their Avidia account, to use on qualified medical expenses. Employees may elect to make additional tax free contributions to their HSA.	

DENTAL

COVERAGE	**Deductible** Annual amount that you will pay before your health insurance begins coverage.	Individual: $50 Family: $150
	Preventive Services Two exams and cleanings twice a year, at least 6 months apart. Bite Wing x-rays once per year; Full Mount x-rays once every three years.	Diagnostic & Preventive (Exams, X-rays, Cleanings): 100%
	Coinsurance The percentage of your healthcare costs that insurance will cover after your costs exceed your annual deductible.	Basic (Fillings, Temporary Pain Relief, Prosthetic Maintenance): 80% after deductible Major (Root Canals, Inlays, Crowns, Bridges, Dentures, Implants, Extractions, Dental Surgery): 50% after deductible Orthodontic Services: not covered Calendar Year Max Benefit: $2,000

VISION

COVERAGE	**Deductible** Annual amount that you will pay before your health insurance begins coverage.	Individual: $0 Family: $0
	Preventive Services	One eye exam covered per calendar year (per covered person)
	Coinsurance The percentage of your healthcare costs that insurance will cover after your costs exceed your annual deductible.	Exam: $10 Materials: $10; up to $200 benefit per calendar year Contact lens fitting & eval: 15% discount (up to $60)

CONTACTS

Allstate Benefits – Administrator	Tel: 888-306-0905	www.allstatebenefits.com
Allied Benefits (member portal)		www.alliedbenefit.com
Recuro Health – Virtual Care Services	Tel: 855-673-2876	www.member.alliedbenefit.com/com/login
Vori Health	Tel: 866-719-9611	www.vorihealth.com/allstate
CIGNA- Prescription Drug		www.myCigna.com
Professional Benefit Services - HSA	Tel: 800-982-2012	www.profben.com
MultiPlan	Tel: 877-952-7427	www.multiplan.com/phcspracanc

EFFECTIVE 1/1/2025

COVERAGE		Employee Share	CC Share	Full Premium
PPO	Employee Only	**$0.00**	$1,017.00	$1,017.00
	Employee & Spouse	**$425.00**	$1,726.00	$2,151.00
	Employee & Child(ren)	**$385.00**	$1,548.00	$1,933.00
	Employee & Family	**$775.00**	$2,291.00	$3,066.00

COVERAGE		EE Share	CC Share Incl Contr	Full Premium
HSA	Employee Only	**$0.00**	$1,039.00	$839.00
	Employee & Spouse	**$250.00**	$1,724.00	$1,774.00
	Employee & Child(ren)	**$245.00**	$1,548.00	$1,593.00
	Employee & Family	**$440.00**	$2,292.00	$2,532.00
	HSA Employer Contribution	**$0.00**	$200.00	

COVERAGE		EE Share	CC Share	Full Premium
Dental Vision	Employee Only	**$0.00**	$100.00	$100.00
	Employee & Spouse	**$20.00**	$180.00	$200.00
	Employee & Child(ren)	**$30.00**	$195.00	$225.00
	Employee & Family	**$90.00**	$237.00	$327.00