

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 or change to full time status.

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 month following current month you are in. Once you work 130+ hours you may elect to enroll in coverage for the following month.

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
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
Allied Benefits (member portal)		www.allstatebenefits.com
Allied Benefits (member portal)		www.alliedbenefit.com
Recuro Health – Virtual Care Services		Tel: 855-673-2876
Vori Health		www.member.alliedbenefit.com/com/login
CIGNA- Prescription Drug		Tel: 866-719-9611
MultiPlan		www.vorihealth.com/allstate
		www.myCigna.com
		Tel: 877-952-7427
		www.multiplan.com/phcspracanc

COVERED		PPO	Dental Vision
EMPLOYEE COST	Employee Only	\$0.00	\$0.00
	Employee & Spouse	\$425.00	\$20.00
	Employee & Child(ren)	\$385.00	\$30.00
	Employee & Family	\$775.00	\$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