COMMUNITY CONNECTIONS HEALTHCARE COVERAGE

ELIGIBILITY: Employees working 130+ hours in a month and their dependents. Dependents may enroll in one or all coverages that the employee is enrolled in.
WAITING PERIOD – NEW HIRES: 1st of month following 30 days from date of employment.
WAITING PERIOD – PT TO FT: 3-month Measurement Period with a 6-month Stability Period
ENROLLMENT: Regular, benefited employees will be contacted prior to their eligibility date to complete paperwork, even if they will be declining coverage.

	COVERED	PPO	HSA	Dental	Vision
EMPLOYEE COST	Employee Only	$0.00	$0.00	$0.00	$0.00
	Employee & Spouse	$325.00	$250.00	$15.00	$5.00
	Employee & Child(ren)	$285.00	$245.00	$20.00	$10.00
	Employee & Family	$675.00	$440.00	$70.00	$20.00

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
	Emergency Room	$350, then covered 100%
	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% Retail Tier 4 Specialty: 30% coinsurance, max $300 Preventive Drugs: $0 Copay

HSA

COVERAGE	**Deductible / Out of Pocket Max** 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
	Emergency Room	0% - Covered in full after deductible / out of pocket max is met
	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** to establish 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 $25**, 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: $0 Materials: subjected to the $500 PYC (per covered person) **Calendar Year Max Benefit $500**

CONTACTS

Meritain – Administrator	Tel: 888-324-5789	www.Meritain.com
Aetna	Tel: 800-343-3140	www.Aetna.com
TelaDoc – Virtual Care Services	Tel: 800-362-2667	www.Teladoc.com
Employee Assistance Program	Tel: 800-854-1446	www.unum.com/lifebalance
Prudent Rx	Tel: 800-578-4403	
Professional Benefit Services - Avidia	Tel: 866-387-1978	profben.wealthcareportal.com
Valenz Health	Tel: 877-438-5479	Used for surgery or major imaging needs.
Transcarent Surgery Benefit	Tel: 800-680-1366	Transcarent.com – find out-of-state surgical assistance