

Franchise January 1, 2024 Health Plan Options

\$25,000 Life & AD&D Included for all Primary Insured Persons

United Healthcare Insurance	EPO Option 1	Premier PPO Option 2	PPO Silver Option 3	H.S.A. Plan Option 4	PPO Bronze Level Option 5	PPO Gold Level Option 6
Plan Name:	CUKU (Select Network)	CUI3 (Select Plus Network)	CQHU (Select Plus Network)	DD6U(Select Plus Network)	CQJC (Select Plus Network)	CQIG (Select Plus Network)
RX: Plan Number	RX Plan: J41S	RX Plan: J41S	RX Plan: J41S	RX Plan: P26S-Intrc Rx	RX Plan: J41S	RX Plan: J41S
Multiple Option with: H.S.A. Eligible	No	No	No	MOTION HSA	No	No
Benefits*	In Network	In Network	In Network	In Network	In Network	In Network
Office Copay (PCP/SPC)	PCP \$20, SPC \$40	PCP \$15, SPC \$30 Deductible Waived	PCP \$10, SPC \$40 Deductible Waived	80% After Deductible	PCP \$35, SPC \$70 Deductible Waived	PCP \$20, SPC \$50 Deductible Waived
Hospital Copays	75% Coinsurance	80% After Deductible	80% covered after \$350 Copay	80% After Deductible	70% After Deductible	80% covered after \$350 Copay
Urgent Care Copays	\$50 Copay	\$50 Copay Deductible Waived	\$50 Copay Deductible Waived	80% After Deductible	\$50 Copay Deductible Waived	\$50 Copay Deductible Waived
Emergency Room	75% Coinsurance	80% After Deductible	\$350 Copay then 80% covered After Deductible	80% After Deductible	70% After Deductible	\$350 Copay then 80% covered After Deductible
Deductible: Single / Family	No Deductible	\$500 / \$1,000 (Emb)	\$2,000 / \$4,000 (Emb)	\$3,500 / \$7,000 (NonEmb)	\$6,000 / \$12,000 (Emb)	\$1,000 / \$2,000 (Emb)
Coinsurance	75% Coinsurance	80% After Deductible	80% After Deductible	80% After Deductible	70% After Deductible	80% After Deductible
Out-of-Pocket: Single/Family	\$5,000 / \$10,000	\$2,500 / \$5,000	\$7,150 / \$14,300	\$5,500 / \$11,000	\$8,550 / \$17,100	\$7,150 / \$14,300
Pharmacy: Retail	\$300 Ded, \$10/\$65/\$125/\$250	\$300 Ded, \$10/\$65/\$125/\$250	\$300 Ded, \$10/\$65/\$125/\$250	Med Ded, \$10/\$65/\$125/\$250	\$300 Ded, \$10/\$65/\$125/\$250	\$300 Ded, \$10/\$65/\$125/\$250
2.5 Co-Pay Mail after \$300 Ded	No Ded. on Tier 1 Generic Drugs	No Ded. on Tier 1 Generic Drugs	No Ded. on Tier 1 Generic Drugs	2.5 Mail Order after Ded	No Ded. on Tier 1 Generic Drugs	No Ded. on Tier 1 Generic Drugs
Out of Network	Out of Network	Out of Network	Out of Network	Out of Network	Out of Network	Out of Network
Deductible: Single / Family	N/A	\$1,500 / \$3,000 (Emb)	\$5,000 / \$10,000	\$7,000 / \$14,000 (NonEmb)	\$18,000 / \$36,000 (NonEmb)	\$5,000 / \$10,000 (Emb)
Coinsurance	N/A	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Out-of-Pocket: Single/Family	N/A	\$7,500 / \$15,000	\$10,000 / \$20,000	\$11,000 / \$22,000	\$26,500 / \$51,200	\$10,000 / \$20,000