United HealthCare - Current/Renewal

The City of Los Fresnos

Carrier:	**United HealthCare**	**United HealthCare**
Plan Type:	**PPO - *Premier***	**PPO - *Premier***
Network:	**ChoicePlus**	**ChoicePlus**
	Current	***Renewal - New Plan Code***
IN-NETWORK BENEFITS	**DQ3T w/G58S**	**EIW7 w/G58S**
Deductible - Calendar Year	**$1500 Ind/$3000 Fam**	**$1500 Ind/$3000 Fam**
Coinsurance	**100%**	**100%**
Annual Coinsurance Limit-Single/Family	**$3000/$6000**	**$3000/$6000**
Annual Coinsurance Limit-Single/Family	***$3000/$6000***	***$3000/$6000***
Office Visit Copay	**$25 PCP** ***$50 Specialist*** *{Child less than 19: $0 Copay}* **Virtual Visits: $0 Copay** **Lab & X-Ray: $0**	**$25 PCP** ***$50 Specialist*** *{Child less than 19: $0 Copay}* **Virtual Visits: $0 Copay** **Lab & X-Ray: $0**
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab and imaging*	**100% after Deductible**	**100% after Deductible**
Preventive Care ***Babies/Children:*** *exam, immunization and necessary lab work*	**100%**	**100%**
Adults *: routine pap smears & mammograms for women and routine PSA's for men*	**100%**	**100%**
Maternity	Included	Included
Home Health Care Services	100% after Deductible *(60 visits)*	100% after Deductible *(60 visits)*
Spinal Manipulation Therapy	**$25 Copay**	**$25 Copay**
Emergency Room Care *If applicable no ER Copay if confined*	**$500 Copay**	**$500 Copay** ***{After Deductible}***
Prescription Drug Benefit	**$10 / $45 / $80** ***Specialty: $10/$150/$500*** *Standard Select - Walgreens*	**$10 / $45 / $80** ***Specialty: $10/$150/$500*** *Standard Select - Walgreens*
Serious Mental Illness ☆***Required for Public Entities*** ☆	**Included**	**Included**
OUT OF NETWORK BENEFITS		
Deductible - Calendar Year	$5000 Ind/$10000 Fam	$5000 Ind/$10000 Fam
Coinsurance	70%	70%
Annual Coinsurance Limit-Single/Family	$10000/$20000	$10000/$20000
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab and imaging*	70% after Deductible	70% after Deductible
Lifetime Maximum	**Unlimited**	**Unlimited**
	Current	**Renewal at 31.61%**
COST OF INSURANCE	**BCX4 w/G58Y**	**EIW7 w/G58S**
EO: Employee Only	**$670.48**	**$882.43**
ES: Employee+Spouse	$670.48+$748.80=**$1419.28**	$882.43+$985.51=**$1867.94**
EC: Employee + Child(ren)	$670.48+$745.57=**$1416.05**	$882.43+$981.26=**$1863.69**
EF: Employee + Family	$670.48+$1494.36=**$2164.84**	$882.43+$1966.75=**$2849.18**
TOTAL GROUP EMPLOYEE COST	**$42,910.72**	**$56,475.52**
TOTAL DEPENDENT COST	$745.57	$981.26
TOTAL GROUP COST	**$43,656.29**	**$57,456.78**

Based on 64 FT Employees: EO=63; ES=0, EC=1, EF=0

United HealthCare - Renewal Options

The City of Los Fresnos

Carrier:	United HealthCare	United HealthCare	United HealthCare	United HealthCare
Plan Type:	PPO - *Premier*	PPO - *Premier*	PPO - *Premier*	POS - HSA
Network:	ChoicePlus	ChoicePlus	ChoicePlus	ChoicePlus
	OPTION 1	*OPTION 2*	*OPTION 3*	*OPTION 4*
IN-NETWORK BENEFITS	**EI1H**	**EIXF**	**EI2T**	**E1T2**
Deductible - Calendar Year	$1000 Ind/$2000 Fam	$1500 Ind/$3000 Fam	$3000 Ind/$6000 Fam	$3500 Ind/$7000 Fam
Coinsurance	80%	80%	100%	100%
Annual Coinsurance Limit-Single/Family	$7150/$14300	$5000/$10000	$8000/$16000	$4000/$8000
Annual Coinsurance Limit-Single/Family	*$7150/$14300*	*$5000/$10000*	*$8000/$16000*	*$4000/$8000*
Office Visit Copay	$10 PCP *$40/$80 Specialist* {Child less than 19: $0 Copay} Virtual Visits: $0 Copay Lab & X-Ray: $40	$25 PCP *$25/$50 Specialist* {Child less than 19: $0 Copay} Virtual Visits: $0 Copay Lab & X-Ray: $0	$30 PCP *$30/$60 Specialist* {Child less than 19: $0 Copay} Virtual Visits: $0 Copay Lab & X-Ray: $0	100% after Deductible
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab and imaging*	80% after Deductible	80% after Deductible	80% after Deductible	100% after Deductible
Preventive Care ***Babies/Children:*** *exam, immunization and necessary lab work*	100%	100%	100%	100%
Adults *: routine pap smears & mammograms for women and routine PSA's for men*	100%	100%	100%	100%
Maternity	Included	Included	Included	Included
Home Health Care Services	80% after Deductible *(60 visits)*	80% after Deductible *(60 visits)*	80% after Deductible *(60 visits)*	100% after Deductible *(60 visits)*
Spinal Manipulation Therapy	$10 Copay *{20 visits per year}*	$25 Copay *{20 visits per year}*	$30 Copay	100% after Deductible
Emergency Room Care *If applicable no ER Copay if confined*	$300 Copay + 20% Coins	$500 Copay + 20% Coins	$500 Copay + 20% Coins	100% after Deductible
Prescription Drug Benefit	$10 / $45 / $80 *Specialty: $10/$150/$500*	$10 / $45 / $80 *Specialty: $10/$150/$500*	$10 / $45 / $80 *Specialty: $10/$150/$500*	$10 / $35 / $70 *Specialty: $10/$150/$500* *{After Deductible}*
Serious Mental Illness ☆*Required for Public Entities*☆	Included	Included	Included	Included
OUT OF NETWORK BENEFITS				
Deductible - Calendar Year	$5000 Ind/$10000 Fam	$5000 Ind/$10000 Fam	$5000 Ind/$10000 Fam	$5000 Ind/$10000 Fam
Coinsurance	50%	50%	70%	70%
Annual Coinsurance Limit-Single/Family	$10000/$20000	$10000/$20000	$10000/$20000	$10000/$20000
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab*	50% after Deductible	50% after Deductible	70% after Deductible	70% after Deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
COST OF INSURANCE	**EI1H**	**EIXF**	**EI2T**	**E1T2**
EO: Employee Only	$785.07	$819.32	$822.27	$690.65
ES: Employee+Spouse	$785.07+$876.78=**$1661.85**	$819.32+$915.03=**$1734.35**	$822.27++918.32=**$1740.59**	$690.65+$771.33=**$1461.98**
EC: Employee + Child(ren)	$785.07+$872.99=**$1658.06**	$819.32+$911.08=**$1730.40**	$822.27+$914.56=**$1736.83**	$690.65+$768.00=**$1458.65**
EF: Employee + Family	$785.07+$1749.76=**$2534.83**	$819.32+$1826.09=**$2645.41**	$822.27+$1833.67=**$2655.94**	$690.65+$1539.31=**$2229.96**
TOTAL GROUP EMPLOYEE COST	$50,244.48	$52,436.48	$52,625.28	$44,201.60
TOTAL DEPENDENT COST	$872.99	$911.08	$914.56	$768.00
TOTAL GROUP COST	$51,117.47	$53,347.56	$53,539.84	$44,969.60

Based on 64 FT Employees: EO=63; ES=0, EC=1, EF=0

Blue Cross Blue Shield of Texas - Mid-Mkt Options

City of Los Fresnos

	Option 5	Option 6	Option 7	Option 8	Option 9
Carrier:	Blue Cross Blue Shield	Blue Cross Blue Shield	Blue Cross Blue Shield	Blue Cross Blue Shield	Blue Cross Blue Shield
Plan Type:	PPO	PPO	PPO	PPO	PPO
Network:	BlueChoice	BlueChoice	BlueChoice	BlueChoice	BlueChoice
IN-NETWORK BENEFITS	**MTBCP515**	**MTBCP514**	**MTBCP011**	**MTBCP509**	**MTBCP507**
Deductible - Calendar Year	$1500 Ind/$4500 Fam	$1500 Ind/$4500 Fam	$1000 Ind/$3000 Fam	$1250 Ind/$3750 Fam	$1250 Ind/$3750 Fam
Coinsurance	70%	80%	80%	70%	100%
Annual Coinsurance Limit-Single/Family	$6500/$16000	$6000/$18000	$4000/$12000	$3750/$11250	$3750/$11250
Annual Coinsurance Limit-Single/Family	*$6500/$16000*	*$6000/$18000*	*$4000/$12000*	*$3750/$11250*	*$3750/$11250*
Office Visit Copay	$40 PCP *$80 Specialist* Lab & X-Ray: No Charge	$40 PCP *$80 Specialist* Lab & X-Ray: No Charge	$30 PCP *$60 Specialist* Lab & X-Ray: No Charge	$35 PCP *$70 Specialist* Lab & X-Ray: No Charge	$35 PCP *$70 Specialist* Lab & X-Ray: No Charge
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab and imaging*	70% after Deductible	80% after Deductible	80% after Deductible	70% after Deductible	100% after Deductible
Preventive Care ***Babies/Children:*** *exam, immunization and necessary lab work*	100%	100%	100%	100%	100%
Adults *: routine pap smears & mammograms for women and routine PSA's for men*	100%	100%	100%	100%	100%
Maternity	Included	Included	Included	Included	Included
Home Health Care Services	70% after Deductible *(60 visits)*	80% after Deductible *(60 visits)*	80% after Deductible *(60 visits)*	70% after Deductible *(60 visits)*	100% after Deductible *(60 visits)*
Spinal Manipulation Therapy	70% after Deductible	80% after Deductible	80% after Deductible	70% after Deductible	100% after Deductible
Emergency Room Care *If applicable no ER Copay if confined*	70% after Deductible *Plus $500 Copay per visit*	80% after Deductible *Plus $500 Copay per visit*	80% after Deductible *Plus $500 Copay per visit*	70% after Deductible *Plus $500 Copay per visit*	$500 Copay
Prescription Drug Benefit	$0/$10/$50/$100/$150/$250 *NP:$10/$20/$70/$120/$150/$250*	$0/$10/$50/$100/$150/$250 *NP:$10/$20/$70/$120/$150/$250*	$0/$10/$50/$100/$150/$250 *NP:$10/$20/$70/$120/$150/$250*	$0/$10/$50/$100/$150/$250 *NP:$10/$20/$70/$120/$150/$250*	$0/$10/$50/$100/$150/$250 *NP:$10/$20/$70/$120/$150/$250*
Serious Mental Illness *☆Required for Public Entities☆*	Included	Included	Included	Included	Included
OUT OF NETWORK BENEFITS					
Deductible - Calendar Year	$3000 Ind/$9000 Fam	$3000 Ind/$9000 Fam	$2000 Ind/$6000 Fam	$10000 Ind/$20000 Fam	$10000 Ind/$20000 Fam
Coinsurance	50%	60%	60%	50%	50%
Annual Coinsurance Limit-Single/Family	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services: IN-PATIENT *also includes: surgery, anesthesia, x-ray, lab and imaging*	50% after Deductible	60% after Deductible	60% after Deductible	50% after Deductible	50% after Deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
COST OF INSURANCE	**MTBCP515**	**MTBCP514**	**MTBCP011**	**MTBCP509**	**MTBCP507**
EO: Employee Only	$653.06	$678.41	$697.75	$702.81	$746.06
ES: Employee+Spouse	$653.06+$848.98=**$1502.04**	$678.41+$881.92=**$1560.33**	$697.75+$907.09=**$1604.84**	$702.81+$913.65=**$1616.46**	$746.06+$969.87=**$1715.93**
EC: Employee + Child(ren)	$653.06+$579.93=**$1232.99**	$678.41+$602.42=**$1280.83**	$697.75+$619.62=**$1317.37**	$702.81+$624.10=**$1326.91**	$746.06+$662.51=**$1408.57**
EF: Employee + Family	$653.06+$1428.91=**$2081.97**	$678.41+$1484.34=**$2162.75**	$697.75+$1526.69=**$2224.44**	$702.81+$1537.74=**$2240.55**	$746.06+$1632.37=**$2378.43**
TOTAL GROUP EMPLOYEE COST	$41,795.84	$43,418.24	$44,656.00	$44,979.84	$47,747.84
TOTAL DEPENDENT COST	$579.93	$602.42	$619.62	$624.10	$662.51
TOTAL GROUP COST	$42,375.77	$44,020.66	$45,275.62	$45,603.94	$48,410.35

Based on 64 FT Employees: EO=63; ES=0, EC=1, EF=0