CLASSIFIED (CSEA)/MANAGEMENT MMA MONTHLY PREMIUMS (REQ'D. 50%+FTE *****) Effective January 1, 2024

A	В	С	D	E (C minus D = E)	F
		MONTHLY	MONTHLY CONTRIBUTION	EMPLOYEE MONTHLY	
MILPITAS PLAN TYPES	NO. COVERED	PREMIUMS	****	CONTRIBUTION *****	GROUP#
NITED HEALTHCARE (UHC), <u>SIGNATURE VALUE</u> , TRADITIONAL HMO HIGH PLAN - FULL NETWORK		1	1		HMO HIGH PLA
office visit co-pay: \$30; Inpatient Hospital: \$750; \$0 Deductible; OOP Maximum \$1,500/\$3,000	Employee Only	1,374.18	1,371.00	3.18	MTA CERT #2521
tx Co-pay: Generic: \$10	Employee+1	2,748.35	1,371.00	1,377.35	CSEA #252198
x Co-pay: Formulary Brand: \$25; Non-Formulary Brand:\$40	Family (3+members)	3,888.92	1,371.00	2,517.92	MGMT #252202
INITED HEALTHCARE (UHC), SIGNATURE VALUE, HMO MID PLAN - FULL NETWORK	Faralaura Oaki	4.007.00	4 007 00		DHMO MID PLA
ffice visit co-pay: \$30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible) .nnual Deductible: \$250/\$500 (Ind/Fam); OOP Maximum: \$2500/\$5000 (Ind/Fam)	Employee Only	1,207.36 2,414.72	1,207.36 1,371.00	1,043.72	MTA CERT #2522
tribual Deductible: \$250/\$500 (Indiram), OOP Maximum: \$2500/\$5000 (Indiram) tx Co-pay: Generic: \$10; Formulary Brand: \$30, Non-formulary Brand: \$50	Employee+1 Family (3+members)	3,416.84	1,371.00	2,045.84	CSEA #252210 MGMT #252211
NITED HEALTHCARE (UHC), SIGNATURE VALUE, HMO LOW PLAN - FULL NETWORK	ranning (S+inembers)	3,410.04	1,37 1.00	2,043.04	WGW1 #25221.
office visit co-pay: \$40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	Employee Only	1,140.15	1,140.15		DHMO LOW PLA
nnual Deductible: \$500/\$1000 (Ind/Fam); OOP Maximum: \$5000/\$10000 (Ind/Fam)	Employee+1	2.280.30	1,371.00	909.30	MTA CERT #2522 CSEA #252220
tx Co-pay: Generic: \$10; Formulary Brand: \$30; Non-Formulary Brand: \$50	Family (3+members)	3,226.61	1,371.00	1,855.61	MGMT #252220
WITTER UT A LINE WAS A SOUNT OF WALLE WAS AND A TOP OF THE WAS A SOUND	NETWORK				
INITED HEALTH CARE (UHC), <u>SIGNATURE VALUE HARMONY</u> , TRADITIONAL HMO HIGH PLAN - LIMITED	1	057.54	057.54		HMO HIGH PLA
office visit co-pay: \$30; Inpatient Hospital: \$750; \$0 Deductible; OOP Maximum \$1,500/\$3,000 tx Co-pay: Generic: \$10	Employee Only Employee+1	957.54 1,915.07	957.54 1,371.00	544.07	MTA CERT #2521
ix Co-pay: Generic: \$10 Ix Co-pay: Formulary Brand: \$25; Non-Formulary Brand:\$40	Family (3+members)	2,709.81	1,371.00	1,338.81	CSEA #252219 MGMT #252219
NITED HEALTHCARE (UHC), SIGNATURE VALUE HARMONY, HMO MID PLAN - LIMITED NETWORK	ir armiy (o members)	2,105.01	1,37 1.00	1,330.01	IVIGIVIT #2522TS
	Employee C-1:	000.40	000.40		
office visit co-pay: \$30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible)	Employee Only	836.18	836.18	-	DHMO MID PLA MTA CERT #2522
nnual Deductible: \$250/\$500 (Ind/Fam); OOP Maximum: \$2500/\$5000 (Ind/Fam)	Employee+1	1,672.36	1,371.00	301.36	CSEA #25220
x Co-pay: Generic: \$10; Formulary Brand: \$30, Non-formulary Brand: \$50	Family (3+members)	2,366.39	1,371.00	995.39	MGMT #25220
NITED HEALTHCARE (UHC), <u>SIGNATURE VALUE HARMONY</u> , HMO LOW PLAN - LIMITED NETWORK		•	1		
office visit co-pay: \$40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	Employee Only	789.07	789.07	-	DHMO LOW PLA
nnual Deductible: \$500/\$1000 (Ind/Fam); OOP Maximum: \$5000/\$10000 (Ind/Fam)	Employee+1	1,578.14	1,371.00	207.14	MTA CERT #252
x Co-pay: Generic: \$10; Formulary Brand: \$30; Non-Formulary Brand: \$50	Family (3+members)	2,233.06	1,371.00	862.06	CSEA #25221: MGMT #25221
DO LINITED LIEAL THOADE (ILLIO) MODIFIED LIGA CELECT DI LIG MITH ODTIONAL HEALTH CAVINGO ACC	OUNT (UCA) DEDUCTIO	E DI ANI			
PO UNITED HEALTHCARE (UHC) MODIFIED HSA, SELECT PLUS, WITH OPTIONAL HEALTH SAVINGS ACC	OUNT (HSA) DEDUCTIBL	LE PLAN			
	L				PPO DEDUCTIB
office visit co-pay: \$0 after ded	Employee Only	1,648.00	1,371.00	277.00	MTA
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam)	Employee+1	3,460.81	1,371.00	2,089.81	MTA
	Employee+1				MTA CERT/CSEA/MG #918667
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded;	Employee+1	3,460.81	1,371.00	2,089.81	MTA CERT/CSEA/MG #918667
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam)	Employee+1 Family (3+members)	3,460.81	1,371.00	2,089.81	MTA CERT/CSEA/MG #918667 HSA#918667SI
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Office visit: \$20; OOP Maximum: \$1500/3000	Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45	1,371.00 1,371.00 925.45	2,089.81 3,605.95	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Uffice visit: \$20; OOP Maximum: \$1500/3000 Apatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year	Employee+1 Employee Only Employee+1	3,460.81 4,976.95	1,371.00 1,371.00	2,089.81	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT	Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45 1,850.90	1,371.00 1,371.00 925.45 1,371.00	2,089.81 3,605.95 - 479.90	MTA CERT/CSEA/MGI #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-03
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Office visit: \$20; OOP Maximum: \$1500/3000 Apatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year AIX Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE	Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02	1,371.00 1,371.00 925.45 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 MGMT 038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) -network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10%	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82	1,371.00 1,371.00 925.45 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02	MTA CERTI/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 MGMT 038160-0 DHMO - MID PL CERT 038160-02
-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) -network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT ffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE ffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 DHMO - MID PLA CERT 038160-02 CLASS 038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-Formulary: \$25 NOSER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Office visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% Ix Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year Ix Co-pay: Brand Formulary: \$30	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82	1,371.00 1,371.00 925.45 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 MGMT 038160-02 CLASS 038160-04 MGMT 038160-02 MGMT 038160-04
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-Formul	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0: CLASS 038160-0 MGMT 038160-0: CERT 038160-0: MGMT 038160-0: MGMT 038160-0: DHMO - MID PLA CERT 038160-0: MGMT 038160-0:
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-Formul	Employee+1 Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	MTA CERT/CSEA/MG #918667 HSA#918667SI CERT 038160-02 CLASS 038160-0 MGMT 038160-0 DHMO - MID PL CERT 038160-0 CLASS 038160-0 MGMT 038160-0 DHMO - LOW PL CERT 038160-038160-038160-038160-038160-038160-038160-038160-038160
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-Formul	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Employee Only Employee+1 Family (3+members) Employee Only Employee Only Employee Only Employee Only Employee+1	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	CERTI/CSEA/MGI #918667 HSA#918667SII HMO HIGH PLA CERT 038160-02 CLASS 038160-02 DHMO - MID PLA CERT 038160-02 CLASS 038160-03 MGMT 038160-03 CLASS 038160-03 CLASS 038160-03 MGMT 038160-03
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-F	Employee+1 Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	MTA CERTICSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 MGMT 038160-02 CLASS 038160-0 MGMT 038160-02 CLASS 038160-02 CLASS 038160-02 CLASS 038160-02 CLASS 038160-03 CLASS 038160-03
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Office visit: \$20; OOP Maximum: \$1500/3000 Inpatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year Ix Co-pay: Generic \$10 Brand Formulary: \$25 IAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Office visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% Ix Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year Ix Co-pay: Brand Formulary: \$30 IAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Office visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% Ix Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year Ix Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year Ix Co-pay: Brand Formulary: \$30	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Employee Only Employee+1 Family (3+members) Employee Only Employee Only Employee Only Employee Only Employee+1	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-00 CLASS 038160-0 MGMT 038160-00 CLASS 038160-0 MGMT 038160-00 CLASS 038160-00 CLASS 038160-00 MGMT 038160-00 MGMT 038160-00 MGMT 038160-00
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 upatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Iffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Employee Only Employee+1 Family (3+members) Employee Only Employee Only Employee Only Employee Only Employee+1	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; Non-Formul	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00 742.14 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0: CLASS 038160-0 MGMT 038160-0: CERT 038160-0: CERT 038160-0: CLASS 038160-0 MGMT 038160-0: CLASS 038160-0 MGMT 038160-0: CLASS 038160-0 MGMT 038160-0: CLASS 038160-0 MGMT 038160-0:
network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT ffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE ffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE ffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN mual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50%	Employee+1 Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00 742.14 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-0
-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) -network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT ffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE ffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE ffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nnual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum	Employee+1 Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23	1,371.00 1,371.00 925.45 1,371.00 1,371.00 881.82 1,371.00 1,371.00 742.14 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-0
-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) -network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT ffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE ffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE ffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nnual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-03
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Iffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nnual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum ENTAL INDEMNITY PLAN o "incentive" feature- Any licensed dentist	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee Only Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00 67.63 135.26 228.66	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 upatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Iffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nnual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum ENTAL INDEMNITY PLAN o "incentive" feature- Any licensed dentist nnual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50%	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00 67.63 135.26 228.66	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-0
network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Iffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nunual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum ENTAL INDEMNITY PLAN o "incentive" feature- Any licensed dentist nual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50%	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee Only Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00 67.63 135.26 228.66	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667S HMO HIGH PL/ CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0
network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT ffice visit: \$20; OOP Maximum: \$1500/300 patient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic \$10 Brand Formulary: \$25 AISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE ffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 AISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE ffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year x Co-pay: Brand Formulary: \$30 ELTA DENTAL PPO PREMIUM PLAN nual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) leanings: 3 per year; Implants: 50% hild/Adult Ortho: 100%, \$3000 maximum ENTAL INDEMNITY PLAN o "incentive" feature- Any licensed dentist nnual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50% hild/Adult Ortho: 100%, \$2,000 Maximums	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00 67.63 135.26 228.66	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667S HMO HIGH PL/ CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; CAISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Inflice visit: \$20; OOP Maximum: \$1500/3000 Inpatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Generic \$10. Brand Formulary: \$25 CAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Inflice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% to co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit: \$40; Annual Deductible: \$3000/\$6000; OOP Maximum \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit: \$40; Annual Deductible: \$4000/\$6000; OOP Maximum: \$6000/\$6000; CO-insurance: 10% to color t	Employee+1 Employee Only Employee+1 Family (3+members) Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00	2,089.81 3,605.95 479.90 1,248.02 392.64 1,124.55 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-03
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded AISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Iffice visit: \$20; OOP Maximum: \$1500/3000 Inpatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year tx Co-pay: Generic \$10. Brand Formulary: \$25 IAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Iffice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% tx Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year tx Co-pay: Brand Formulary: \$30 IAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Iffice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% tx Co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year tx Co-pay: Brand Formulary: \$30 IELTA DENTAL PPO PREMIUM PLAN Innual Maximum Allowance: \$3,200 (in-network) / \$3,000 (out-of-network) Ideanings: 3 per year; Implants: 50% Innual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50% Innual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50% Innual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50% Innual Maximum Allowance: \$2,500: Cleanings: 2 per year: Implants 50% Innual Maximum Allowance: \$2,000 Maximums ISION SERVICE (VSP) HIGH PLAN Io-pay: \$15 every 12 months Exam (in-network), up to \$45 (out-of-network)	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 742.14 1,371.00 1,371.00 67.63 135.26 228.66	2,089.81 3,605.95 - 479.90 1,248.02 - 392.64 1,124.55 - 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-02 CLASS 038160-0 MGMT 038160-02 CLASS 038160-02 CLASS 038160-03 CLASS 038160-03 CLASS 038160-03 CLASS 038160-03 OT102-11190
n-network Annual Deductible: \$2800/\$5600 (Ind/Fam); OOP Maximum: \$2800/\$5600 (Ind/Fam) n-network Rx Co-pay: Generic: \$10 after ded; Formulary Brand: \$30 after ded; Non-Formulary Brand: \$50 after ded; CAISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT Inflice visit: \$20; OOP Maximum: \$1500/3000 Inpatient Hospital: \$500; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Generic \$10. Brand Formulary: \$25 CAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE Inflice visit: \$20; Annual Deductible: \$500/\$1000; OOP Maximum: \$3000/\$6000; Co-insurance: 10% to co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Generic: \$10; Chiropractic co-pay:\$10 (ded waived) limited to 20 visits per calendar year to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit:\$40; Annual Deductible: \$3000/\$6000; OOP Maximum: \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit: \$40; Annual Deductible: \$3000/\$6000; OOP Maximum \$6000/\$12000; Co-insurance: 30% to co-pay: Brand Formulary: \$30 CAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE Inflice visit: \$40; Annual Deductible: \$4000/\$6000; OOP Maximum: \$6000/\$6000; CO-insurance: 10% to color t	Employee+1 Employee Only Employee Only Employee Only Employee Only Employee Only Employee+1 Family (3+members) Employee Only Employee+1 Family (3+members)	3,460.81 4,976.95 925.45 1,850.90 2,619.02 881.82 1,763.64 2,495.55 742.14 1,484.26 2,100.23 67.63 135.26 228.66	1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00 1,371.00	2,089.81 3,605.95 479.90 1,248.02 392.64 1,124.55 113.26 729.23	MTA CERT/CSEA/MG #918667 HSA#918667SI HMO HIGH PLA CERT 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 CLASS 038160-0 MGMT 038160-0 CLASS 038160-0 MGMT 038160-0 ACA-038160-03

^{*****} Employees with monthly premium contributions will have summer share contributions. These contributions apply towards the summer months' benefits when you don't earn normal paychecks (June to July and/or June to August). Summer Share is for less than (<) 12 month employees (11, 10.5, and 9.5 month).*****

Matrix Rate sheets and explanation of Benefits and Summaries are available at MUSD Payroll and Benefits website: https://www.workterra.net (Forms and Library) Employees who waive MUSD benefits must provide proof of coverage.

Per carriers' agreement: If you waive MUSD medical benefits within 30 days of your eligibility, you must wait during Open Enrollment month that same year you were hired to enroll OR within 30 days of a qualifying event.

Per carriers' and SCCSIG's agreement: If you waive MUSD dental and vision benefits within 30 days of your eligibility, you must wait during Open Enrollment month that same year you were hired to enroll, within 30 days of a qualifying event, and/or 3 years after your initial eligibility. Dental and Vision plans Open Enrollment plan is every 3 years, unless you have a 30 day qualifying event.

Per carriers' requirements: If adding family members onto MUSD benefits, you must complete the audit and provide legal documents (marriage certificated, Declaration of Domestic Partnership, birth certificates, court documents for legal adoption, etc.). Without documents, family members will not be enrolled onto the plans.

As an employee of MUSD, you are responsible in understanding your benefits prior to obtaining health, dental, and vision services.

Contact Payroll@musd.org if you have any questions.

^{*****} District's and part-time permanent employees' monthly premium contributions are pro-rated based on part-time FTE.*****