Precision Personnel Inc

Summary of Plan Benefits

Coverage: 8-01-19 to 7-31-20

Comprehensive Care.

Traditional Plan Options & Health Savings Account Plan Options

United Healthcare

Reliance Standard

Principal

Medical. Dental. Vision. Life.

Precision Personnel Inc - Medical Plans August 2019 - July 2020

UnitedHealthcare

	United Healthcare Choice Plus Medical Plans with Health Savings Account		United Healthcare Choice Plus Medical Plans with Traditional Copayment	
In Network Benefits	HEALTH SAVINGS ACCOUNT Plan 1	HEALTH SAVINGS ACCOUNT Plan 2	TRADITIONAL Plan 1	TRADITIONAL Plan 2
	AQSK HSA	AHM8 HSA	AQPL	AQOU
General Plan Info:	CLICK HERE: COMPLETE PLAN INFO	CLICK HERE: COMPLETE PLAN INFO	CLICK HERE: COMPLETE PLAN INFO	CLICK HERE: COMPLETE PLAN INFO
Deductible Deductible is an amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. Deductibles run January - December. Any deductible amount you've already accumulated with United Healthcare in 2019 will continue on with your current plan or new plan for the remainder of 2019.	$2,500 Individual Deductible $5,000 Family Deductible	$2,000 Individual Deductible $4,000 Family Deductible	$1,500 Individual Deductible $3,000 Family Deductible	$500 Individual Deductible $1,500 Family Deductible
	Non-Embedded Deductible: The total family deductible must be paid out-of-pocket before the insurer starts paying for healthcare services for any individual member		Embedded Deductible: No single individual on a family plan will have to pay a deductible higher than the individual deductible amount	
Out of Pocket Max Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. It includes deductible, all copays & prescriptions, but not premiums.	$4,000 Individual / $6,850 Family out of pocket maximum		$4,000 Individual or $8,000 Family out of pocket maximum	$3,000 Individual or $6,000 Family out of pocket maximum
Coinsurance Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service	Member 20% & UHC 80%	Member 10% & UHC 90%	Member 0% & UHC 100%	Member 20% & UHC 80%
Illness & Injury Care:				
Primary Care Physician Visit / Specialist Visit	20% after Deductible	10% after Deductible	$25 Copay Primary Care Visit / $50 Copay Specialist Visit	
Virtual Visit w/ doc via phone, ipad, computer	20% after Deductible	10% after Deductible	$10 Copay	
Urgent Care Visit	20% after Deductible	10% after Deductible	$100 Copay	$75 Copay
Emergency Room Visit	20% after Deductible	10% after Deductible	$350 Copay	$250 Copay
Inpatient Hospital Copay	20% after Deductible	10% after Deductible	0% after Deductible	20% after Deductible
Outpatient Surgery	20% after Deductible	10% after Deductible	0% after Deductible	20% after Deductible
Diagnostics: Lab work & X-rays	20% after Deductible	10% after Deductible	Covered 100% In Network No Deductible & No Copay	
Imaging: MRI, CT, PET	20% after Deductible	10% after Deductible	0% after Deductible	20% after Deductible
Wellness & Preventative Care:				
Wellness exam general check-up Well child care: exams, immunizations, lab tests Woman's care: exam, pap smear, mammogram	Covered 100% In Network No Deductible & No Copay		Covered 100% In Network No Deductible & No Copay	
Prescription Drug Benefit:	$10 Generic Rx / $35 Preferred Rx / $60 Specialty Rx after Deductible		$10 Generic Rx / $35 Preferred Rx / $70 Specialty Rx	
Out of Network Deductible	$5,000 Individual / $10,000 Family	$5,000 Individual / $10,000 Family	$3,000 Individual / $6,000 Family	$1,000 Individual / $3,000 Family
Out of Network Out of Pocket Max	$10,000 Individual / $20,000 Family	$10,000 Individual / $20,000 Family	$6,000 Individual / $12,000 Family	$6,000 Individual / $12,000 Family
Out of Network Coinsurance	Member 50% & UHC 50%	Member 50% & UHC 50%	Member 20% & UHC 80%	Member 40% & UHC 60%
Lifetime Maximum Benefit **In-network & Out-of-network**	Unlimited		Unlimited	

Precision Personnel Inc - August 2019 - July 2020

RELIANCE STANDARD LIMITED MEDICAL PLAN

BasicAdvantage Total Plan

Visit any doctor or hospital.

Enrolled dependents receive the same coverage as you.

No pre-existing conditions, exclusions or limitations.

BasicAdvantage Total Plan enrollees also receive these added, non–insurance benefits:

Prescription Drug Card offering discounts at participating pharmacies.

VSP Access Plan membership offering discounts on eye exams and prescription glasses at network doctors.

24-Hour Nurse Helpline.

On-line Wellness Assistance.

Vitamins & Nutritional Supplements Plan.

On Call Travel Assistance.

In Network	Benefits
Click link to view online plan summary:	SUMMARY LINK
Deductible	$0.00
Coinsurance	0%
Out of Pocket Max	Maximums vary based on services performed. See above summary link for full detail.
Lifetime Maximum	Maximums vary based on services performed. See above summary link for full detail.
Primary Care Physician Copay or Specialist Copay	**New Patient:** $100 / 1 per coverage year **Established Patient:** $70 / 8 per coverage year **Consultive Office Visit:** $150 / 1 per coverage year
Prevantative Services - Wellness exam	**Wellness Care Benefits with Minimum Essential Coverage**
Women's Preventative Care - Annual Gynecological Exam - Pap Smear Screening - Mammography	 Covered 100% Covered 100% Covered 100%
Hospital & Emergency Medical	**Urgent Care:** $50 / 1 per coverage year **ER Visit for Accidental Injury:** $500 / 2 per coverage year **ER Visit for Sickness:** $50 / 3 per coverage year
Major Diagnostics	**Pathology & X-rays** $50 / 5 each per coverage year **MRI** $200 / 1 per coverage year **CT Scan** $100 / 1 per coverage year
Prescription Drug Benefit	**Generic** $25 per script / 24 per coverage year **Brand** $50 per script / 6 per coverage year

*** This is a general outline of covered benefits and does not include all benefits, limitations and exclusions of the policies.***

Precision Personnel Inc - August 2019 - July 2020

PRINCIPAL INSURANCE: DENTAL, LIFE & VISION PLANS

DENTAL INSURANCE

Principal

CLICK HERE TO VIEW FULL PLAN SUMMARY

Exams, X-Rays, Cleanings	$0 Deductible & 0% Copay
Fillings, Oral Surgery, Root Canal	$50 Deductible & 20% Copay
Crowns, Bridges, Dentures, Periodontal Surgery	$50 Deductible & 50% Copay

Maximum Policy Benefit $1,000 per year

LIFE INSURANCE

Principal

CLICK HERE TO VIEW FULL PLAN SUMMARY

Employee	EMPLOYEE 1x Annual Salary - Minimum $25,000 / Maximum $100,000
Spouse	$5,000
Children	$2,000

VISION INSURANCE

Principal

CLICK HERE TO VIEW FULL PLAN SUMMARY

Exams	$10 Copay
Prescription Glasses	$25 Copay
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18. Two lenses (one pair) every 12 months.
Frames	$150 allowance for a wide selection of frames; 20% off amount over allowance. One set every 12 months.
Necessary Contacts	$25 copay. Once every 12 months. Covered in full for members who have specific conditions. Contacts are instead of frames and lenses.
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation) Once every 12 months. Contacts are instead of frames and lenses.

Additional Savings on glasses and sunglasses, contacts and Laser Vision Correction! See plan summary for details.