

Plan Design Layout



\$1,000 Deductible Plan	In-Network	Out-of-Network
Deductible	\$1,000 Individual \$2,000 Family	\$1,000 Individual \$2,000 Family
Out-of-Pocket Maximum	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family
Preventive Care	100% Coverage	80% after Deductible
Office Visits	80% after Deductible	80% after Deductible
Hospital Visits	80% after Deductible	80% after Deductible
Prescription Coverage	\$15 - \$45 Copay Range 2x copay for 93 day mail order supply	80% after Deductible
Prescription Out-of-Pocket Maximum	\$500 Individual \$750 Family	

Plan Design Layout

\$1,700 HSA Deductible Plan	In-Network	Out-of-Network
Deductible	\$1,700 Individual \$3,400 Family	\$1,700 Individual \$3,400 Family
Out-of-Pocket Maximum	\$1,700 Individual \$3,400 Family	\$2,075 Individual \$3,650 Family
Preventive Care	100% Coverage	80% after Deductible
Office Visits	100% after Deductible	80% after Deductible
Hospital Visits	100% after Deductible	80% after Deductible
Prescription Coverage	100% after Deductible 31 day retail supply/ 93 day mail order	80% after Deductible
Prescription Out-of-Pocket Maximum	Not applicable	

Plan Design Layout



\$3,375 HSA Deductible Plan	In-Network	Out-of-Network
Deductible	\$3,375 Individual \$6,750 Family	\$3,375 Individual \$6,750 Family
Out-of-Pocket Maximum	\$3,375 Individual \$6,750 Family	\$3,750 Individual \$7,125 Family
Preventive Care	100% Coverage	80% after Deductible
Office Visits	100% after Deductible	80% after Deductible
Hospital Visits	100% after Deductible	80% after Deductible
Prescription Coverage	100% after Deductible 31 day retail supply/ 93 day mail order	80% after Deductible
Prescription Out-of-Pocket Maximum	Not applicable	

Dental Plan Highlights Low Option



Delta Dental of Minnesota

Covered Services	Delta PPO Network	Delta Premier Network	Non-Participating Dentist
Deductible	\$50/person \$150/Family	\$50/person \$150/Family	\$50/person \$150/Family
Annual Maximum	\$1,000 Per Person	\$1,000 Per Person	\$1,000 Per Person
Diagnostic & Preventative Services	100%	100%	100%
Basic Services	50%	50%	50%
Oral Surgery	50%	50%	50%

Dental Plan Highlights High Option



Delta Dental of Minnesota

Covered Services	Delta PPO Network	Delta Premier Network	Non-Participating Dentist
Deductible	\$50/person \$150/Family	\$50/person \$150/Family	\$50/person \$150/Family
Annual Maximum	\$1,500 Per Person	\$1,500 Per Person	\$1,500 Per Person
Diagnostic & Preventative Services	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Orthodontics	50%	50%	50%
Lifetime Ortho Maximum	\$2,000	\$2,000	\$2,000

Vision Plan Summary



Benefit Category	In-network coverage
Frames – every other plan year	\$0 copay; \$150 allowance + 20% off balance over \$150
Lenses – every plan year	\$20 co-pay for standard and lined lenses. Progressives and coatings are extra co-pays
Conventional Contacts – every plan year	\$0 copay; \$150 allowance + 15% off balance over \$150
Hearing Care and Lasik	Discounts through networks providers



Insight network – check eyemed.com for providers

Vision Plan Rates- No Change



Monthly Vision Premiums	1/1/25 Rates
Employee Coverage	\$5.59
Employee plus 1 Coverage	\$10.62
Employee plus Children Coverage	\$11.18
Family Coverage	\$16.43

