

INTEGRITY CONSULTING

HEALTH INSURANCE GROUP PLAN OPTIONS

Integrity offers group health insurance to all full-time employees who will be employed longer than 90 days.

There is a 90 day waiting period on all coverage

The plan includes 3 different options, "base plan", "buy up" plan and "alternate plan"

Integrity covers 50% of either the base plan or alternate plan. If you opt for buy-up plan, integrity covers 50% of the base plan rate

Employees can add dependents, but are responsible for 100% of the premiums.

Dental, Vision and Disability can be added for employee and dependent but employee covers entire premium. Integrity does not have life insurance

Prices change annually, usually around April 1st

AGE BANDED PRICE LISTS

Prices listed are the total monthly price (not employee portion).

effective 4/1/2018

Prices for children will be based on their age

ALTERNATE PLAN		AV-DN	
Age	Price	Age	Price
<15	\$ 202.53	40	\$ 338.35
15	\$ 220.54	41	\$ 344.70
16	\$ 227.42	42	\$ 350.79
17	\$ 234.30	43	\$ 359.26
18	\$ 241.71	44	\$ 369.86
19	\$ 249.13	45	\$ 382.30
20	\$ 256.81	46	\$ 397.13
21	\$ 264.75	47	\$ 413.80
22	\$ 264.75	48	\$ 432.86
23	\$ 264.75	49	\$ 451.66
24	\$ 264.75	50	\$ 472.85
25	\$ 265.81	51	\$ 493.76
26	\$ 271.10	52	\$ 516.79
27	\$ 277.46	53	\$ 540.09
28	\$ 287.79	54	\$ 565.24
29	\$ 296.25	55	\$ 590.39
30	\$ 300.49	56	\$ 617.66
31	\$ 306.85	57	\$ 645.20
32	\$ 313.20	58	\$ 674.59
33	\$ 317.18	59	\$ 689.14
34	\$ 321.40	60	\$ 718.53
35	\$ 323.53	61	\$ 743.95
36	\$ 325.64	62	\$ 760.63
37	\$ 327.76	63	\$ 781.54
38	\$ 329.88	64	\$ 794.25
39	\$ 334.11		

BASE PLAN		AV-EB	
Age	Price	Age	Price
<15	\$ 249.13	40	\$ 416.21
15	\$ 271.28	41	\$ 424.02
16	\$ 279.75	42	\$ 431.51
17	\$ 288.22	43	\$ 441.93
18	\$ 297.33	44	\$ 454.96
19	\$ 306.46	45	\$ 470.27
20	\$ 315.90	46	\$ 488.51
21	\$ 325.67	47	\$ 509.02
22	\$ 325.67	48	\$ 532.47
23	\$ 325.67	49	\$ 555.59
24	\$ 325.67	50	\$ 581.65
25	\$ 326.97	51	\$ 607.37
26	\$ 333.48	52	\$ 635.71
27	\$ 341.30	53	\$ 664.36
28	\$ 354.01	54	\$ 695.31
29	\$ 364.43	55	\$ 726.25
30	\$ 369.64	56	\$ 759.78
31	\$ 377.45	57	\$ 793.66
32	\$ 385.26	58	\$ 829.81
33	\$ 390.15	59	\$ 847.72
34	\$ 395.36	60	\$ 883.87
35	\$ 397.97	61	\$ 915.14
36	\$ 400.58	62	\$ 935.65
37	\$ 403.18	63	\$ 961.38
38	\$ 405.79	64	\$ 977.01
39	\$ 411.00		

BUY UP PLAN		AV-FE	
Age	Price	Age	Price
<15	\$262.22	40	\$438.06
15	\$285.53	41	\$446.29
16	\$294.44	42	\$454.17
17	\$303.35	43	\$465.13
18	\$312.95	44	\$478.84
19	\$322.54	45	\$494.96
20	\$332.49	46	\$514.16
21	\$342.77	47	\$535.74
22	\$342.77	48	\$560.43
23	\$342.77	49	\$584.77
24	\$342.77	50	\$612.19
25	\$344.14	51	\$639.26
26	\$350.99	52	\$669.09
27	\$359.22	53	\$699.25
28	\$372.59	54	\$731.82
29	\$383.56	55	\$764.37
30	\$389.05	56	\$799.68
31	\$397.27	57	\$835.34
32	\$405.50	58	\$873.38
33	\$410.64	59	\$892.24
34	\$416.12	60	\$930.28
35	\$418.87	61	\$963.19
36	\$421.60	62	\$984.78
37	\$424.35	63	\$1,011.86
38	\$427.09	64	\$1,028.31
39	\$432.58		

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HEALTH INSURANCE GROUP PLANS SUMMARIES

PLAN	ALTERNATE PLAN	EV-DN
Coinsurance	50%	50%
Deductible	In -Network	Out of Network
Individual Deductible	\$5,000	\$10,000
Family Deductible	\$10,000	\$20,000
Out of Pocket Max		
Individual Max	\$7,350	\$14,700
Family Max	\$14,700	\$29,400
Lifetime Maximum	Unlimited	Unlimited
Primary Care	\$50 CoPay Virtual \$10	50% after Ded
Specialist	\$100 CoPay	50% after Ded
Preventative Care		
Routine exams, Well Child Care, Immunizations, OBGYN exams, Cervical Cancer Screening, Ovarian Cancer screenings, mammograms, colorectal screening, bone mass measurements	100%	50% after Ded

BASE PLAN	AV-EB
80%	60%
In -Network	Out of Network
\$2,500	\$5,000
\$5,000	\$10,000
\$5,000	\$10,000
\$10,000	\$20,000
Unlimited	Unlimited
\$30 CoPay	60% after Ded
\$60 CoPay	60% after Ded
100%	60% after ded

BUY UP PLAN	AV-FE
80%	60%
In -Network	Out of Network
\$1,000	\$2,000
\$2,000	\$4,000
\$5,000	\$10,000
\$12,000	\$24,000
Unlimited	Unlimited
\$30 CoPay Virtual \$10	60% after Ded
Designated Network: \$60 CoPay Network: Ded 60%	60% after Ded
100%	60% after Ded

PLAN	ALTERNATE PLAN EV-DN	
Hospitalization		
Out-Patient Surgery	50% after Ded	50% after Ded
Outpatient Labs and Mammograms with surgery or other services. Outpatient Labs and Mammograms without surgery or other services. Outpatient x-rays, ultrasounds, and other diagnostic test	50% after Ded	50% after Ded
Major Diagnostic: EEG's and EKG's. CT scans, MRI's, MRA's and PET scans in any location, including physicians office.	50% after Ded	50% after Ded
In-Patient Hospitalization / Surgery	50% after Ded	50% after Ded
Emergency Room	50% after Ded	50% after Ded
Urgent Care Center	\$50 CoPay	50% after Ded
RX		
Tier 1 Preferred Generic	\$15 CoPay	
Tier 2 Non-Pref Generic	\$50 CoPay	
Tier 3 Preferred Brand	\$85 CoPay	
Tier 4 Non-Pref. Brand	\$200 CoPay	
Tier 5 Specialty		
Vision		
Routine Eye Exam	Pediat. Only 100%	N/A

BASE PLAN	AV-EB
80% after Ded	60% after Ded
100% after Ded	70% after Ded
80% after Ded	60% after Ded
80% after Ded	60% after Ded
\$250/80% after Ded	\$250/80% after Ded
\$50 CoPay	60% after Ded
\$10 CoPay	
\$35 CoPay	
\$70 CoPay	
\$150 CoPay	
Pediat. Only 100%	N/A

BUY UP PLAN	AV-FE
\$250 CoPay and then 80% after Ded	\$250 CoPay and then 60% after Ded
100%	60% after Ded
80% after Ded	60% after Ded
\$500 CoPay and then 80% after Ded	\$500 CoPay and then 60% after Ded
\$250 CoPay	\$250 CoPay
\$50 CoPay	60% after Ded
\$10 CoPay	
\$35 CoPay	
\$70 CoPay	
\$150 CoPay	
Pediat. Only 100%	N/A

* Information for summary purposes only. See complete plan for official details

INTEGRITY CONSULTING

VISION PLAN from UNITED HEALTHCARE

Vision plan is separate and covered 100% by employee and is completely voluntary
They offer discounts on non-covered options to reduce out-of pocket expenses (may not be in all states)
Both private practice and retail providers
Access to discounted laser vision correction procedures
Covered-in-full benefits for eye exams, eyeglasses and contact lenses (after applicable copayment)
Premium digital hearing aid discount program

COVERAGE SUMMARY

Services & Materials

Exam Copay	\$10
Materials Copay	\$25

Frequencies

Exam	12 Months
Lenses	12 Months
Frames	24 Months

Retail Frame Allowance

\$130
30% discount on frame overage at participating providers

Contact Lens Benefit

Fitting/evaluation fees, contacts, and up to 2 follow-up visits are covered-in-full (after applicable copay)
For disposable lenses, up to 4 boxes are included For disposable lenses, up to 4 boxes are included
All other elective contacts - \$105 Allowance

Out of Network Allowance

Exam	Up to \$40
Single Vision Lenses	Up to \$40
Frames	Up to \$45
Contact Lenses	Up to \$105

PRICE LIST

Employee Only	\$6.73
Employee & Spouse	\$12.79
Employee & Child(ren)	\$14.95
Employee & Family	\$21.08

** Information for summary purposes only. See complete plan for official details*

Plans are completely voluntary, employee is responsible for 100% of premium
 Plans are with United HealthCare

The Out of Network reimbursements may be based on a percentage of the Usual and Customary (UCR) or
 Maximum Allowable Charges (MAC) service that would have been rendered by a network provider.

The Out of Network reimbursements are based on the geographic area in which the expenses are incurred.

****This information is for summary purposes only, See plan for complete details and restrictions***

Price List

Employee Only	\$31.82
Employee & Spouse	\$63.65
Employee & Child(ren)	\$69.70
Employee & Family	\$106.58

Coverage

Deductible (Individual /Family)	50/150
Annual Plan Maximum	\$1,000
Preventive Services	100%
Basic Dental Services	80%
Endodontics	50%
Periodontics	50%
Oral Surgery	50%
Major Services	50%

Currently there is no Orthodontia coverage

It is possible if enough people enroll it could be added

Extras

Extended benefits during pregnancy

Oral cancer screenings for all adults that covers light contrast screenings and brush biopsies

Access to an extensive national network of dentists and the freedom to visit non-network dentists

Both Long and Short Term Disability plans are offered
 Plans are completely voluntary, employee is responsible for 100% of premium
 Plans are with The Hartford

****This information is for summary purposes only, See plan for complete details and restrictions***

Short Term Disability

Starts on 8th day
 Covers up to 12 weeks
 60% of weekly earnings up to a max of \$2,000/week

Long Term Disability

Starts after 90 days
 66.67% of monthly earnings up to a max of \$10,000/month

Price List

Short Term	\$.285 per \$10 weekly benefit
Long Term	\$.31 per \$100 covered salary

*Short Term Example: An employee makes \$1200/week, the cost of short term would be \$20.52 per month
 (\$1200 / \$10 = \$120, \$120 * .285 = \$34.20, \$34.20 * 60% = \$20.52)*

*Long Term Example: An employee makes \$5000/month, the cost of the long term would be \$15.50 per month
 (\$5000 / \$100 = \$50, \$50 * .31 = \$15.50)*