FOCUS + STAFF

INSURANCE
INFORMATIONAL

BROCHURE 2025

United Healthcare

United Healthcare

MEDICAL PLAN BASE OPTION

Carrier Name	United Healthcare	
Plan Type	United Healthcare HSA Base	
Network Name	United Healthcare HSA - EAA6/MM	
Metallic Level	--	
	In	Out
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Coinsurance	100%	70%
Individual Out of Pocket Maximum	$5,000	$20,000
Family Out of Pocket Maximum	$10,000	$40,000
PCP Copay	0% after Ded.	30% after Ded.
Specialist Copay	0% after Ded.	30% after Ded.
Lab and X-ray	0% after Ded.	30% after Ded.
Advanced Imaging	0% after Ded.	30% after Ded.
Prescription Drug Card	0% after Ded. Preferred / 30% after Ded. Non-Preferred	
In Network Specialty Medication	0% after Ded.	
Mail Order Benefit	0% after Ded.	N/A
Urgent Care Copay	0% after Ded.	30% after Ded.
Emergency Room Copay	0% after Ded.	0% after Ded.
Inpatient Hospitalization	0% after Ded.	30% after Ded.
Outpatient Surgery	0% after Ded.	30% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at Ded & Coins	
Employee Only	$144.88/monthly	
Employee + Spouse	$576.00/monthly	
Employee + Child(ren)	$623.01.08/monthly	
Employee + Family	$1,146.90/monthly	

MEDICAL PLAN MID OPTION

Carrier Name	United Healthcare	
Plan Type	United Healthcare PPO - Mid	
Network Name	United Healthcare PPO - EADP Mod/QF	
Metallic Level	--	
	In	Out
Individual Deductible	$5,000	$10,000
Family Deductible	$14,700	$29,400
Coinsurance	30%	50%
Individual Out of Pocket Maximum	$5,600	$20,000
Family Out of Pocket Maximum	$14,700	$60,000
PCP Copay	$35 copay	50% after Ded.
Specialist Copay	35 designated $70 network	50% after Ded.
Lab and X-ray	30% after Ded.	50% after Ded.
Advanced Imaging	30% after Ded.	50% after Ded.
Prescription Drug Card	$45 - Preferred $15/$85 - Non-Preferred	
In Network Specialty Medication	$212.50 copay	
Mail Order Benefit	$37.50 Copay	N/A
Urgent Care Copay	$50 Copay	50% after Ded.
Emergency Room Copay	$500 + 30% + Ded.	$500 + 30% + Ded.
Inpatient Hospitalization	30% after Ded.	50% after Ded.
Outpatient Surgery	30% after Ded.	50% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at $45	
Employee Only	$187.90/monthly	
Employee + Spouse	$543.29/monthly	
Employee + Child(ren)	$526.29/monthly	
Employee + Family	$1,360.91/monthly	

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MEDICAL PLAN HIGH OPTION

Carrier Name	United Healthcare	
Plan Type	United Healthcare PPO - High	
Network Name	United Healthcare EADK MOD/QF	
Metallic Level	--	
	In	Out
Individual Deductible	$2,000	$4,000
Family Deductible	$6,000	$12,000
Coinsurance	20%	60%
Individual Out of Pocket Maximum	$5,000	$10,000
Family Out of Pocket Maximum	$14,700	$30,000
PCP Copay	$30	40% after Ded.
Specialist Copay	$30 designated $60 network	40% after Ded.
Lab and X-ray	$0.00	40% after Ded.
Advanced Imaging	20% after Ded.	40% after Ded.
Prescription Drug Card	$45 – Preferred $15 / $85 – Non-Preferred	
In Network Specialty Medication	$212.50 copay	
Mail Order Benefit	$37.50 copay	N/A
Urgent Care Copay	$75 copay	40% after Ded.
Emergency Room Copay	$500 + 20% + Ded.	$500 + 20% + Ded.
Inpatient Hospitalization	20% after Ded.	40% after Ded.
Outpatient Surgery	20% after Ded.	40% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at $30	

Employee Only	$313.26/monthly
Employee + Spouse	$832.96/monthly
Employee + Child(ren)	$914.64/monthly
Employee + Family	$1,598.42/monthly

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DENTAL PLAN LOW OPTION

Summary of Dental Benefits	
Program Basics	
Benefit Period Maximum	**$750/ person**
Deductible	**$25 Individual / $75 Family**
Covered Services	
Diagnostic Evaluations • Periodic Oral Evaluations • Problem Focused Oral Evaluations • Comprehensive Oral Evaluations	**100%** **(Deductible does not apply)**
Preventive Services • Prophylaxis (Cleanings) • Topical Fluoride Applications	**100%** **(Deductible does not apply)**
Diagnostic Radiographs • Full-Mouth and Panoramic Films • Bitewing Films • Periapical Films	**100%** **(Deductible does not apply)**
Miscellaneous Preventive Services • Sealants • Space Maintainers	**100%** **(Deductible does not apply)**
Basic Restorative Dental Services • Amalgams • Resin-based Composite Restorations	**80%**
Non-Surgical Extractions • Removal of retained coronal remnants • Removal of erupted tooth or exposed root	**Not Covered**
Non-Surgical Periodontal Services • Periodontal Scaling and Root Planing • Full-mouth Debridement • Periodontal Maintenance Procedures	**Not Covered**
Adjunctive Services • Palliative Treatment (Emergency) • Deep Sedation / General Anesthesia	**Not Covered**
Endodontic Services • Therapeutic pulpotomy and pulpal debridement • Root Canal Therapy • Apexification / Recalcification	**Not Covered**

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DENTAL PLAN LOW OPTION

CONTINUATION

Oral Surgery Services • Surgical Tooth Extractions • Alveoloplasty and Vestibuloplasty • Excision of Bone Tissue • Incision and Drainage of an Intraoral Abscess	**Not Covered**
Surgical Periodontal Services • Gingivectomy or Gingivoplasty and Gingival Flap Procedures • Clinical Crown Lengthening • Osseous Surgery • Osseous Grafts • Soft Tissue Grafts/Allografts • Distal or Proximal Wedge Procedure • Anatomical Crown Exposures	**Not Covered**
Major Restorative Services • Single Crown Restorations • Gold Foil and Inlay/Onlay Restorations • Labial Veneer Restorations • Crowns Placed over Implants	**Not Covered**
Prosthodontic Services • Complete and Removable Partial Dentures • Denture Reline/Rebase Procedures • Fixed Bridgework • Prosthetics placed over implants	**Not Covered**
Miscellaneous Restorative and Prosthodontic Services • Prefabricated Crowns • Recementations • Post and Core, Pin Retention and Crown/Bridge Repairs • Adjustments	**Not Covered**
Orthodontic Services	
Orthodontic Services • Orthodontic Diagnostic Procedures and Treatment • Lifetime Maximum per Participant	**Not Covered**

Employee Only	**$11.03/monthly**
Employee + Spouse	**$22.05/monthly**
Employee + Child(ren)	**$34.23/monthly**
Employee + Family	**$50.59/monthly**

United Healthcare

DENTAL PLAN HIGH OPTION

Summary of Dental Benefits	
Program Basics	
Benefit Period Maximum	**$1,500 per person**
Deductible	**$50 Individual / $150 Family**
Covered Services	
Diagnostic Evaluations • Periodic Oral Evaluations • Problem Focused Oral Evaluations • Comprehensive Oral Evaluations	**100%** **(Deductible does not apply)**
Preventive Services • Prophylaxis (Cleanings) • Topical Fluoride Applications	**100%** **(Deductible does not apply)**
Diagnostic Radiographs • Full-Mouth and Panoramic Films • Bitewing Films • Periapical Films	**100%** **(Deductible does not apply)**
Miscellaneous Preventive Services • Sealants • Space Maintainers	**100%** **(Deductible does not apply)**
Basic Restorative Dental Services • Amalgams • Resin-based Composite Restorations	**80%**
Non-Surgical Extractions • Removal of retained coronal remnants • Removal of erupted tooth or exposed root	**Not Covered**
Non-Surgical Periodontal Services • Periodontal Scaling and Root Planing • Full-mouth Debridement • Periodontal Maintenance Procedures	**Not Covered**
Adjunctive Services • Palliative Treatment (Emergency) • Deep Sedation / General Anesthesia	**Not Covered**
Endodontic Services • Therapeutic pulpotomy and pulpal debridement • Root Canal Therapy • Apexification / Recalcification	**Not Covered**

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DENTAL PLAN HIGH OPTION

CONTINUATION

Oral Surgery Services • Surgical Tooth Extractions • Alveoloplasty and Vestibuloplasty • Excision of Bone Tissue • Incision and Drainage of an Intraoral Abscess	**50%**
Surgical Periodontal Services • Gingivectomy or Gingivoplasty and Gingival Flap Procedures • Clinical Crown Lengthening • Osseous Surgery • Osseous Grafts • Soft Tissue Grafts/Allografts • Distal or Proximal Wedge Procedure • Anatomical Crown Exposures	**50%**
Major Restorative Services • Single Crown Restorations • Gold Foil and Inlay/Onlay Restorations • Labial Veneer Restorations • Crowns Placed over Implants	**50%**
Prosthodontic Services • Complete and Removable Partial Dentures • Denture Reline/Rebase Procedures • Fixed Bridgework • Prosthetics placed over implants	**50%**
Miscellaneous Restorative and Prosthodontic Services • Prefabricated Crowns • Recementations • Post and Core, Pin Retention and Crown/Bridge Repairs • Adjustments	**50%**
Orthodontic Services	
Orthodontic Services • Orthodontic Diagnostic Procedures and Treatment • Lifetime Maximum per Participant	**50%** **$1,000/monthly** **(Deductible does not apply)**

Employee Only	**$25.29/monthly**
Employee + Spouse	**$50.57/monthly**
Employee + Child(ren)	**$68.44/monthly**
Employee + Family	**$103.66/monthly**

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VISION PLAN

Vision Care Service	Member Cost In-Network	Out of Network Reimbursement
Exam with Dilation as Necessary	$10/monthly Copay	Up to $30/monthly
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Exam Options:		
Standard Contact Lens Fit and Follow Up:	$40	N/A
Frames:		
Any available frame at provider location	$10 Copay; $130 Allowance,	Up to $65/monthly
Standard Plastic Lenses:		
Single Vision	$10	Up to $25/monthly
Bifocal	$10	Up to $40/monthly
Trifocal	$10	Up to $55/monthly
Lenticular	$10	Up to $55/monthly
Standard Progressive Lens	$55	Up to $40/monthly
Premium Progressive Lens	$250	Up to $40/monthly
Lens Options:		
UV Treatment	$16	N/A
Tint (Solid and Gradient)	$14	N/A
Standard Plastic Scratch Coating	$0	Up to $5/monthly
Standard Polycarbonate – Adults	$63	N/A
Standard Polycarbonate – Kids under 19	$33	Up to $5/monthly
Standard Anti-Reflective Coating	$30	N/A
Polarized	20% off retail price	N/A
Photochromatic/Transitions Plastic	$67	N/A
Premium Anti-Reflective	$95	N/A
Contact Lenses (Contact lens allowance includes materials only):		
Conventional	$10 Copay; $130 allowance	Up to $104/monthly
Disposable	$10 Copay; $130 allowance	Up to $104/monthly
Medically Necessary	$0 Copay, Paid in Full	Up to $210/monthly
Laser Vision Correction:		
Lasik or PRK from U.S. Laser Network	N/A	N/A
Additional Pairs Benefit:	additional 30% discount may be applied to overage	N/A

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VISION PLAN

CONTINUATION

Progressive Price List*	Member Cost In-Network
Standard Progressive	$0
Premium Progressives as Follows:	
• Tier 1	$55
• Tier 2	$100
• Tier 3	$150
• Tier 4	$250
Anti-Reflective Coating Price List*	
Standard Anti-Reflective Coating	$0
Premium Anti-Reflective Coating as Follows:	
• Tier 1	$30
• Tier 2	$50
• Tier 3	$75
Other Add-Ons Price List*	
Photochromic (Plastic)	$67

Employee Only	**$7.55/monthly**
Employee + Spouse	**$14.35/monthly**
Employee + Child(ren)	**$15.11/monthly**
Employee + Family	**$22.21/monthly**