

**AMERICANA GROUP  
Health Insurance Plan Rates**

<b>Benefit Summary</b>	<b>UHC #1</b>	<b>UHC #2</b>	<b>UHC #3</b>
Deductible (individual/family)	\$5000/\$10000	\$3000/\$6000	\$1500/\$3000
Coinsurance % (plan/insured)	100/0	100/0	100/0
Out-of-Pocket Expense (individual/family) (includes deductible)	\$6250/\$12500	\$6250/\$12500	\$4000/\$8000
Office Visits (Primary Care/Specialist)	\$35/\$70/\$100	\$35/\$70/\$100	\$25/\$50/\$100
Prescription Drugs (Generic/Brand Formulary/ Brand Non-Formulary)	\$15/\$40/\$75	\$15/\$40/\$75	\$15/\$40/\$75
Preventive Care	100%	100%	100%
Inpatient Services	\$500 copay/ded/coins	\$500 copay/ded/coins	100/0
Outpatient Services	\$250 copay/ded/coins	\$250 copay/ded/coins	100/0
Emergency	\$500 copay/coins	\$500 copay/coins	\$300 copay/coins
Network	UHC	UHC	UHC
<b>Rate Summary</b>			
	<u>Standard</u>	<u>Standard</u>	<u>Standard</u>
Employee	\$333.03	\$356.31	\$434.60
Employee/Spouse	\$699.28	\$748.17	\$912.56
Employee/Child	\$650.20	\$695.65	\$848.51
Family	\$1014.95	\$1,085.90	\$1,324.49

**All benefits are in-network unless otherwise indicated.  
Refer to the plan SBC for out of network benefits**

**Dimond Bros. Insurance Agency**

*Group & Individual Health Insurance  
Dental, Life, Disability, Vision  
Section 125 Cafeteria plans*

**Employer pays 75% of employee coverage and 40% of dependent coverage for Standard Option 1**

Choose a lower deductible and employee pays the difference in cost

Please check the box coverage needed or waive insurance below

No Medical Coverage desired

April 2018-March 2019

	<input checked="" type="checkbox"/> Monthly Premium	Weekly Employee Pays	Weekly Employer Pays	<b>Standard Offering Option 1</b>
0% Co-Ins Once Deductible meet	333.03	19.21	57.64	Employee only
PPO5,000Single/10,000family	650.2	63.13	86.92	Employee/Child
Max 6,250Single/\$12,500family	699.28	69.92	91.45	Employee/Spouse
RX1 \$15/\$40/\$75	1014.95	113.63	120.59	Family

Copay: \$35/SPEC \$70,ER \$100

April 2018-March 2019

	<input checked="" type="checkbox"/> Monthly Premium	Weekly Employee Pays	Weekly Employer Pays	<b>Premium Plan 3000, Option 2</b>
0% Co-Ins Once Deductible meet	356.31	24.59	57.64	Employee only
PPO3000Single/6,000family	695.65	73.62	86.92	Employee/Child
Max 6,250Single/\$12,500family	748.17	81.21	91.45	Employee/Spouse
RX1 \$15/\$40/\$75	1085.9	130.01	120.59	Family

Copay: \$35/SPEC \$70,ER \$100

April 2018-March 2019

	<input checked="" type="checkbox"/> Monthly Premium	Weekly Employee Pays	Weekly Employer Pays	<b>Premium Plan 1500, Option 3</b>
0% Co-Ins Once Deductible meet	434.6	42.65	57.64	Employee only
PPO1500Single/3,000family	848.51	108.89	86.92	Employee/Child
Max 4,000Single/\$8,000family	912.56	119.14	91.45	Employee/Spouse
RX1 \$15/\$40/\$75	1324.49	185.07	120.59	Family

Copay: \$25/SPEC \$50,ER \$100

Vision Plan

No Vision Coverage desired

	Monthly	Weekly Employee pays		
	6.35	1.47	-	Employee only
	10.37	2.39	-	Employee/Child
	10.16	2.34	-	Employee/Spouse
	16.72	3.86	-	Family

Employee Signature

Date

Coverage will begin on:

Return this form to [brenda@americana.com](mailto:brenda@americana.com)

Questions: Call Brenda 618-740-0513

April 1<sup>st</sup>, 2018

 **UnitedHealthcare®**  
12501 Whitewater Dr  
Minnetonka, MN 55343  
1-888-842-4571

Welcome to

**UnitedHealthcare.**

Thank you for placing your trust in us. We'll work hard to help you and your employees get the most out of your benefits.

- **Member Customer Service:** For questions about benefits and claims, members may call the toll-free member phone number on their health plan ID card. They may also have access to the Care24® assistance line, where registered nurses can answer questions about symptoms and appropriate care. Care24 is not available in all markets or with all products. For **Disability Claims** Service, call 1-888-299-2070.
- **myuhc.com®**: Employees should register at myuhc.com for easy access to their Certificate of Coverage, personal benefit information and a simple, engaging wellness tools. Registration is easy. Just follow the quick self- registration process. myuhc.com is only available to employees who have medical or dental coverage and/or financial products such as an FSA. It takes 24 to 48 hours from the date of this letter for access to benefits to become available. For Vision customers, visit myuhcvision.com.

Group Name: AMERICANA BUILDING PRODUCTS, INC.

Effective Date: 4/1/2018

Customer Number (if applicable): 03X4089

Policy Number(s): 03X2873, 03X2872, 03X2878

03X2873:

0% Co-Ins Once Deductible meet

PPO5,000Single/10,000family

Max 6,250Single/\$12,500family

RX1 \$15/\$40/\$75

Copay: \$35/SPEC \$70,



03X2872:

0% Co-Ins Once Deductible meet

PPO3000Single/6,000family

Max 6,250Single/\$12,500family

RX1 \$15/\$40/\$75

Copay: \$35/SPEC \$70

03X2878:

0% Co-Ins Once Deductible meet

PPO1500Single/3,000family

Max 4,000Single/\$8,000family

RX1 \$15/\$40/\$75

Copay: \$25/SPEC \$50,