2024 Employee Benefits Summary

TEAM offers four group medical insurance plan options – Platinum, Gold, Silver, and Bronze – as well as a Dental and Vision plan. Individuals can enroll in Dental and Vision separately from the Medical plan.

MEDICAL: UNITED HEALTHCARE								
Calendar Year Benefits	Select Plus PPO Platinum		Select Plus PPO Gold		Select Plus PPO Silver		Select Plus PPO Bronze	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible - Single	$250	$1,000	$1,500	$3,000	$2,450	$4,900	$6,000	$12,000
Deductible - Family	$500	$2,000	$3,000	$6,000	$4,900	$9,800	$12,000	$24,000
Out of Pocket Maximum - Single	$3,800	$7,600	$9,450	$18,900	$9,450	$18,900	$9,450	$18,900
Out of Pocket Maximum - Family	$7,600	$15,200	$18,900	$37,800	$18,900	$37,800	$18,900	$37,800
Coinsurance	80%	50%	70%	50%	60%	50%	60%	50%
Preventative Care	0%	N/A	0%	N/A	0%	N/A	0%	N/A
Office Visits - Primary Care	$15	N/A	$10	N/A	$55	N/A	40% After Deductible	N/A
Office Visits - Specialist	$30	N/A	$70	N/A	$95	N/A	40% After Deductible	N/A
Hospital – Inpatient or Outpatient	20% After Deductible	N/A	30% After Deductible	N/A	40% After Deductible	N/A	40% After Deductible	N/A
Diagnostic Lab and X-ray	20% After Deductible	N/A	30% After Deductible	N/A	40% After Deductible	N/A	40% After Deductible	N/A
Urgent Care	$50	N/A	$50	N/A	$80	N/A	40% After Deductible	N/A
Emergency Room	20% After Deductible	N/A	30% After Deductible	N/A	40% After Deductible	N/A	40% After Deductible	N/A
Prescription Drugs - Deductible	$0	N/A	$300 Single $600 Family (N/A to Tier 1)	N/A	$350 Single $700 Family (N/A to Tier 1)	N/A	$500 Single $1000 Family (N/A to Tier 1)	N/A
Prescription Deductible - Single	$0	N/A	$300	N/A	$350	N/A	$500	N/A
Prescription Deductible - Family	$0	N/A	$600	N/A	$700	N/A	$1000	N/A
Prescription Deductible - Tier 1	$10	N/A	$5	N/A	$20	N/A	$20	N/A
Prescription Deductible - Tier 2	$35	N/A	$50	N/A	$85	N/A	$85	N/A
Prescription Deductible - Tier 3	$70	N/A	$100	N/A	$135	N/A	$135	N/A
Prescription Deductible - Tier 4	25% to $250	N/A	25% to $250	N/A	25% to $250	N/A	25% to $500	N/A
Specialty	Varies by Tier	N/A	Varies by Tier	N/A	Varies by Tier	N/A	Varies by Tier	N/A

2024 Medical Plan Monthly Premiums

Select Plus PPO Platinum

Plan Code: DH-99 RX Plan Code: P56S

Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate
<15	$422.88	20	$536.21	27	$579.32	33	$662.24	40	$706.47	46	$829.19	53	$1,127.69	59	$1,438.91
15	$460.47	21	$552.79	28	$600.88	34	$671.09	41	$719.73	47	$864.01	54	$1,180.21	60	$1,500.27
16	$474.85	22	$552.79	29	$618.57	35	$675.51	42	$732.45	48	$903.81	55	$1,232.72	61	$1,553.34
17	$489.22	23	$552.79	30	$627.42	36	$679.93	43	$750.14	49	$943.06	56	$1,289.66	62	$1,588.17
18	$504.70	24	$552.79	31	$640.68	37	$684.35	44	$772.25	50	$987.28	57	$1,347.15	63	$1,631.84
19	$520.18	25	$555.00	32	$653.95	38	$688.78	45	$798.23	51	$1,030.95	58	$1,408.51	64+	$1,658.37
		26	$566.06			39	$697.62			52	$1,079.05				

Select Plus PPO Gold

Plan Code: DI-AJ RX Plan Code: L40S

Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate
<15	$353.73	20	$448.52	27	$484.58	33	$553.94	40	$590.93	46	$693.59	53	$943.28	59	$1,203.60
15	$385.17	21	$462.39	28	$502.62	34	$561.34	41	$602.03	47	$722.72	54	$987.20	60	$1,254.93
16	$397.19	22	$462.39	29	$517.41	35	$565.04	42	$612.67	48	$756.01	55	$1,031.13	61	$1,299.32
17	$409.22	23	$462.39	30	$524.81	36	$568.74	43	$627.46	49	$788.84	56	$1,078.76	62	$1,328.45
18	$422.16	24	$462.39	31	$535.91	37	$572.44	44	$645.96	50	$825.83	57	$1,126.84	63	$1,364.98
19	$435.11	25	$464.24	32	$547.01	38	$576.14	45	$667.69	51	$862.36	58	$1,178.17	64+	$1,387.17
		26	$473.49			39	$583.54			52	$902.59				

Select Plus PPO Silver

Plan Code: DI-AH RX Plan Code: L41S

Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate
<15	$317.33	20	$402.37	27	$434.72	33	$496.94	40	$530.13	46	$622.22	53	$846.21	59	$1,079.75
15	$345.54	21	$414.81	28	$450.90	34	$503.58	41	$540.08	47	$648.35	54	$885.62	60	$1,125.79
16	$356.32	22	$414.81	29	$464.17	35	$506.90	42	$549.62	48	$678.21	55	$925.03	61	$1,165.62
17	$367.11	23	$414.81	30	$470.81	36	$510.22	43	$562.90	49	$707.67	56	$967.75	62	$1,191.75
18	$378.72	24	$414.81	31	$480.76	37	$513.53	44	$579.49	50	$740.85	57	$1,010.89	63	$1,224.52
19	$390.34	25	$416.47	32	$490.72	38	$516.85	45	$598.99	51	$773.62	58	$1,056.94	64+	$1,244.43
		26	$424.77			39	$523.49			52	$809.71				

Select Plus PPO HDHP Bronze*

Plan Code: DI-AA RX Plan Code: L42S

Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate	Age	Rate
<15	$291.12	20	$369.13	27	$398.82	33	$455.90	40	$486.34	46	$570.83	53	$776.32	59	$990.57
15	$317.00	21	$380.55	28	$413.66	34	$461.99	41	$495.48	47	$594.80	54	$812.47	60	$1,032.81
16	$326.89	22	$380.55	29	$425.84	35	$465.03	42	$504.23	48	$622.20	55	$848.63	61	$1,069.35
17	$336.79	23	$380.55	30	$431.92	36	$468.08	43	$516.41	49	$649.22	56	$887.82	62	$1,093.32
18	$347.44	24	$380.55	31	$441.06	37	$471.12	44	$531.63	50	$679.66	57	$927.40	63	$1,123.38
19	$358.10	25	$382.07	32	$450.19	38	$474.17	45	$549.51	51	$709.73	58	$969.64	64+	$1,141.65
		26	$389.68			39	$480.25			52	$742.83				

*Select Plus PPO HDHP Bronze total employee contribution when enrolled at the Employee Only level (no dependents) is capped at 8.0% of the employee's annual wages.

2024 Dental and Vision Benefits Summary

DENTAL: DENTAL GUARD PREFERRED

	In Network	Out of Network
Deductible - Single	$50	$50
Deductible - Family	$150	$150
Preventive	Plan Pays 100%	Plan Pays 100%
Basic	Plan Pays 80%	Plan Pays 80%
Major	Plan Pays 50%	Plan Pays 50%
Orthodontia – Coinsurance	Not Covered	
Annual Maximum	$1,000 Per Person	
Maximum Rollover	Yes	
Rollover Threshold	$500	
Rollover Amount	$250	
Rollover In Network Amount	$350	
Rollover Account Limit	$1,000	

Monthly Premium	
Employee	$27.59
Employee + Spouse	$56.00
Employee + Child	$67.97
Employee + Family	$102.60

VISION: DAVIS VISION

	In Network	Out of Network
Vision Exam	$10 Copay	$10 Copay (Then Plans Pays Up To $50)
Prescription Glasses	$25 Copay	$25 Copay
Lenses	Single Vision Lined Bifocal Lined Trifocal Lenticular Included in Glasses Copay Every Calendar Year	Plan Pays $48 Plan Pays $67 Plan Pays $86 Plan Pays $126 Included in Glasses Copay Every Calendar Year
Frames Allowance	$130 Every 24 Months	Plan Pays $48 Every 24 Months
Contacts (In Lieu of Frames and Lens)	$130 Every Calendar Year	$130 Every Calendar Year

Monthly Premium	
Employee	$7.59
Employee + Spouse	$14.36
Employee + Child	$14.63
Employee + Family	$23.15