SELF-PAY PREMIUMS - COBRA CONTINUATION (UP TO 18 MONTHS, 29 MONTHS, OR 36 MONTHS MAXIMUM ELIGIBILITY)

COBRA Enrollment (UP TO 18 MONTHS MAXIMUM ELIGIBILITY PERIOD)- enrollee can only continue current plans through COBRA Continuation. For example, if you are currently enrolled in either Medical, Dental or Vision plan, you can continue COBRA one and/or all of these plan(s). You are NOT eligible to enroll in a new plan to add under COBRA if you weren't previously enrolled in the plan. Premiums due every 1st of the month of coverage, payable to MUSD. MUSD has the right to terminate your coverage without notice if you fail to pay your premiums. You have between the 1st and 10th of the month to pay your premiums. There is a $25 fee for all returned checks. MUSD will not issue a monthly invoice. Therefore, it is your responsibility to pay your remium to keep coverage active. If for any reason, you cannot pay premium on time, please inform our office in writing. We will note on your file when to expect the payment. Otherwise your coverage will be terminated without notice.

UNPAID LEAVE SELF-PAY PREMIUM BEGINS THE 1ST OF THE FOLLOWING MONTH OR,
COBRA ELIGIBILITY BEGINS JULY 1ST IF EMPLOYEE'S LAST OFFICIAL WORK CONTRACT ENDED JUNE 30TH (YOU DIDN'T WORK ANY DAYS THE BEGINNING OF THE FOLLOWING SCHOOL YEAR)
ALL employees: SELF-PAY PREMIUM BEGINS THE 1ST OF THE FOLLOWING MONTH AFTER YOUR RESIGNATION MONTH.
IF YOU ARE NOT RETURNING TO WORK THE FOLLOWING SCHOOL YEAR, BENEFITS END JUNE 30TH THE PREVIOUS YEAR

PLAN TYPES (COBRA CONTINUATION)	NO. COVERED	SELF-PAY MONTHLY PREMIUMS	ADMIN FEES 2%	*SELF-PAY 102% MONTHLY PREMIUMS*	GROUP NUMBERS
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE, TRADITIONAL HMO HIGH PLAN - FULL NETWORK					
Office visit co-pay: $30; Inpatient Hospital: $750	Employee Only	1,045.59	20.91	1,066.50	COBRA
Rx Co-pay: Generic: $10	Employee+1	2,091.18	41.82	2,133.00	HIGH PLAN CO-PAY
Rx Co-pay: Formulary Brand: $25; Non-Formulary Brand:$40	Family (3+members)	2,959.02	59.18	3,018.20	#252201
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE, HMO MID PLAN - FULL NETWORK					
Office visit co-pay: $30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible)	Employee Only	918.65	18.37	937.02	
Annual Deductible: $250/$500 (Ind/Fam); OOP Maximum: $2500/$5000 (Ind/Fam)	Employee+1	1,837.30	36.75	1,874.05	DHMO MID #252213
Rx Co-pay: Generic: $10; Formulary Brand: $30, Non-formulary Brand: $50	Family (3+members)	2,599.78	52.00	2,651.78	
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE, HMO LOW PLAN - FULL NETWORK					
Office visit co-pay: $40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	Employee Only	867.52	17.35	884.87	DHMO LOW
Annual Deductible: $500/$1000 (Ind/Fam); OOP Maximum: $5000/$10000 (Ind/Fam)	Employee+1	1,735.04	34.70	1,769.74	#252223
Rx Co-pay: Generic: $10; Formulary Brand: $30; Non-Formulary Brand: $50	Family (3+members)	2,455.08	49.10	2,504.18	
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE ADVANTAGE, TRADITIONAL HMO HIGH PLAN - LIMITED NETWORK					
Office visit co-pay: $30; Inpatient Hospital: $750	*Employee Only*	*981.77*	*19.64*	*1,001.41*	*COBRA*
Rx Co-pay: Generic: $10	*Employee+1*	*1,963.54*	*39.27*	*2,002.81*	*HIGH PLAN CO-PAY*
Rx Co-pay: Formulary Brand: $25; Non-Formulary Brand:$40	*Family (3+members)*	*2,778.41*	*55.57*	*2,833.98*	*#252194*
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE ADVANTAGE, HMO MID PLAN - LIMITED NETWORK					
Office visit co-pay: $30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible)	*Employee Only*	*857.34*	*17.15*	*874.49*	*DHMO MID*
Annual Deductible: $250/$500 (Ind/Fam); OOP Maximum: $2500/$5000 (Ind/Fam)	*Employee+1*	*1,714.68*	*34.29*	*1,748.97*	*#252208*
Rx Co-pay: Generic: $10; Formulary Brand: $30, Non-formulary Brand: $50	*Family (3+members)*	*2,426.27*	*48.53*	*2,474.80*	
EFFECTIVE 01/01/2020: UNITED HEALTH CARE (UHC), SIGNATURE VALUE ADVANTAGE, HMO LOW PLAN - LIMITED NETWORK					
Office visit co-pay: $40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	*Employee Only*	*809.04*	*16.18*	*825.22*	*DHMO LOW*
Annual Deductible: $500/$1000 (Ind/Fam); OOP Maximum: $5000/$10000 (Ind/Fam)	*Employee+1*	*1,618.08*	*32.36*	*1,650.44*	*#252218*
Rx Co-pay: Generic: $10; Formulary Brand: $30; Non-Formulary Brand: $50	*Family (3+members)*	*2,289.58*	*45.79*	*2,335.37*	
EFFECTIVE 01/01/2020: PPO UNITED HEALTH CARE (UHC) MODIFIED HSA, SELECT PLUS, WITH OPTIONAL HEALTH SAVINGS ACCOUNT (HSA) DEDUCTIBLE PLAN					
Office visit co-pay: $0 after ded	Employee Only	1,018.19	20.36	1,038.55	COBRA PPO
In-network Annual Deductible: $2800/$5600 (Ind/Fam); OOP Maximum: $2800/$5600 (Ind/Fam)	Employee+1	2,138.20	42.76	2,180.96	DEDUCTIBLE
In-network Rx Co-pay: Generic: $10 after ded; Formulary Brand: $30 after ded; Non-Formulary Brand: $50 after ded	Family (3+members)	3,074.93	61.50	3,136.43	#918667
KAISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT PLAN					
Office visit: $20; Inpatient Hospital: $500; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee Only	710.19	14.20	724.39	038160-7210
Rx Co-pay: generic $10	Employee+1	1,420.38	28.41	1,448.79	038160-7510
Rx Co-pay: Brand Formulary: $25	Family (3+members)	2,009.84	40.20	2,050.04	038160-7110
KAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE					
Office visit: $20; Annual Deductible: $500/$1000; OOP Maximum: $3000/$6000; Co-insurance: 10%	Employee Only	675.32	13.51	688.83	COBRA DHMO MID
Rx Co-pay: Generic: $10; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee+1	1,350.63	27.01	1,377.64	DEDUCTIBLE PLAN
Rx Co-pay: Brand Formulary: $30	Family (3+members)	1,911.14	38.22	1,949.36	038160-7232
KAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE					
Office visit:$40; Annual Deductible: $3000/$6000; OOP Maximum: $6000/$12000; Co-insurance: 30%	Employee Only	565.41	11.31	576.72	
Rx Co-pay: Generic: $10; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee+1	1,130.83	22.62	1,153.45	COBRA DHMO LOW
Rx Co-pay: Brand Formulary: $30	Family (3+members)	1,600.12	32.00	1,632.12	038160-7331
DELTA DENTAL PPO PREMIUM PLAN					
Annual Maximum Allowance: $3,200 (in-network) / $3,000 (out-of-network)	Employee Only	64.72	1.29	66.01	
Cleanings: 3 per year; Implants: 50%	Employee+1	129.43	2.59	132.02	ACTIVE: 0710211190
Child/Adult Ortho: 50%, $2000 maximum	Family (3+members)	218.81	4.38	223.19	COBRA: 0710211191
VISION SERVICE (VSP) HIGH PLAN					
Co-pay: $15 Every 12 months Exam (in-network), up to $45 (out-of-network)	Employee Only	8.53	0.17	8.70	
Frames: Every 24 months; co-pay combined with exam, up to $130 allowance; 20% discount over the allowance amount	Employee+1	17.05	0.34	17.39	ACTIVE 293125A
Lenses: Every 12 months; Contact Lenses: $0 co-pay, up to $130 allowance/ up to $105 (out-of-network)	Family (3+members)	32.21	0.64	32.85	COBRA 2931235A
ADULT ED (AYER AND ELMWOOD ONLY) - KAISER WITH DELTA DENTAL RIDER WITHIN THE KAISER PLAN (NO SEPARATE DELTA DENTAL PLAN) & VISION PLAN WITH VSP					
Kaiser Permanente Traditional HMO High Plan With Delta Dental Rider~					
Office visit Co-pay: $20; Inpatient Hospital: $500	Employee Only	768.01	15.36	783.37	COBRA
Rx Co-pay: generic $10	Employee+1	1,536.02	30.72	1,566.74	HIGH PLAN CO-PAY
Rx Co-pay: Brand Formulary: $25	Family (3+members)	2,173.47	43.47	2,216.94	038160-7310
Kaiser Permanente Deductible HMO Mid Plan With Delta Dental Rider~					
Office visit: $20; Annual Deductible: $500/$1000; OOP Maximum: $3000/$6000; Co-insurance: 10%	Employee Only	732.97	14.66	747.63	
Rx Co-pay: Generic: $10	Employee+1	1,465.93	29.32	1,495.25	COBRA DHMO MID
Rx Co-pay: Brand Formulary: $30	Family (3+members)	2,074.30	41.49	2,115.79	038160-7313
Kaiser Permanente Deductible HMO Low Plan With Delta Dental Rider~					
Office visit:$40; Annual Deductible: $3000/$6000; OOP Maximum: $6000/$12000; Co-insurance: 30%	Employee Only	617.05	12.34	629.39	
Rx Co-pay: Generic: $10	Employee+1	1,234.09	24.68	1,258.77	DHMO LOW
Rx Co-pay: Brand Formulary: $30	Family (3+members)	1,746.24	34.92	1,781.16	
VISION SERVICE (VSP) HIGH PLAN					
Co-pay: $15 Every 12 months Exam (in-network), up to $45 (out-of-network)	Employee Only	8.53	0.17	8.70	
Frames: Every 24 months; co-pay combined with exam, up to $130 allowance; 20% discount over the allowance amount	Employee+1	17.05	0.34	17.39	ACTIVE 293125A
Lenses: Every 12 months; Contact Lenses: $0 co-pay, up to $130 allowance/ up to $105 (out-of-network)	Family (3+members)	32.21	0.64	32.85	COBRA 2931235A