2024 UR COBRA Benefits

COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, requires group health plans to offer temporary continuation coverage to you and your eligible dependents (qualified beneficiaries) after a qualifying event or loss of group health coverage. This is a summary of those benefits to help you make the right decisions when you enroll.

As a COBRA participant, you have the choice to elect to keep your current benefit offerings. You may also choose to remove coverage that you have previously elected. The following benefits may be continued through COBRA - medical, dental, and vision.

Medical Plan Summary

	Anthem Blue Cross Gold Plan		Anthem Blue Cross Silver Plan		Anthem Blue Cross Bronze Plan		Kaiser Permanente*
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Calendar Year Deductible							
Individual	$250	$500	$2,000	$4,000	$3,000	$6,000	$0
Family	$750	$1,500	$4,000**	$8,000**	$6,000**	$11,000**	$0
Calendar Year Out-Of-Pocket Maximum (Includes Deductible)							
Individual	$5,000	$10,000	$6,000	$11,000	$6,000	$11,000	$1,500
Family	$10,000	$30,000	$11,000	$33,000	$11,000	$33,000	$3,000
Copays/Coinsurance							
Primary Care Physician	$25	50%***	20%***	50%***	30%***	50%***	$25
Specialist	$45	50%***	20%***	50%***	30%***	50%***	$40

* Available to employees in the following states only: California, Colorado, Mid Atlantic, Georgia, Northwest and Washington.
** For coverage types other than Employee Only, the deductible will automatically default to the family deductible.
*** Copay/cost share applies after plan deductible is met.

Dental Plan Summary

	Cigna DPPO			DHMO
	CIGNA ADVANTAGE NETWORK	CIGNA DPPO NETWORK/ OUT-OF-AREA**	OUT-OF-NETWORK***	IN-NETWORK ONLY
Calendar Year Deductible				
Individual	$50	$100	$100	N/A
Family	$100	$200	$200	N/A
Calendar Year Benefit Maximum (Excluding Orthodontia)				
Individual	$2,000 per individual (Basic and Major Services combined)	$1,000 per individual (Basic and Major Services combined)		N/A
Services				
Basic Services	10%*	20%*	10%*	Preset copays provided in Patient Charge Schedule
Major Procedures	50%*	50%*	50%*	
Orthodontia (children up to 19th birthday and adults)	50%* up to a lifetime maximum of $2,000			

* Copay applies after plan deductible is met.
** For employees who do not have a participating primary dentist within 25 miles of their home.
*** Out-of-network provider fees over the Plan's reasonable and customary limits are your responsibility.

Vision Plan Summary

The vision plan offers in- and out-of-network benefits to help you pay for the cost of routine eye exams, glasses and contacts.

	VSP Vision Plan	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You Pay	Reimbursement
Cost		
Exam	$25	Up to $45
Covered Services – Lenses		
Single Lenses	COVERED	Up to $65 depending on lens type and option
Bifocals		
Trifocals		
Frames	Balance over $150 allowance	Up to $70
Covered Services – Contacts in Lieu of Frames/Lenses*		
Contacts – Medically Necessary	$0	Up to $210
Contacts – Elective	Balance over $150 allowance	Up to $105
Benefit Frequency		
Exams	Every Calendar Year	
Lenses		
Frames		
Contacts		

* There is up to a $60 copay for your contact lens exam (fitting and evaluation). The Vision Plan covers either lenses with frames or content lenses, but not both. If you choose to switch to eyeglasses, they are covered 12 months from the date you obtained contact lenses.