

# Benefits Overview

Proven Recruiting Core CA Employees

January 1, 2024



## Medical Insurance | Anthem Blue Cross

| Choice of plan options:  | Priority HMO<br><i>In-Network Benefits Only</i>   | Value HMO<br><i>In-Network Benefits Only</i>                     | PPO 3500  | High Deductible PPO with H.S.A   |
|--|---|--|---|--|
| <b>Network</b>   | Priority Select HMO   | Select HMO   | Prudent Buyer PPO   | Prudent Buyer PPO  |
| <b>Deductible</b><br>Individual<br>(In / Out-of-Network)<br>Family<br>(In / Out-of-Network)  | \$3,000<br>\$6,000  | \$0<br>\$0   | \$3,500 / \$10,500<br>\$7,000 / \$21,000                                | \$4,500 / \$13,500<br>\$9,000 / \$27,000   |
| <b>Coinsurance</b><br>(In / Out-of-Network)  | 70%   | 70%  | 70% / 50%   | 80% / 50%  |
| <b>Out-of-Pocket Max</b><br>Individual<br>(In / Out-of-Network)<br>Family<br>(In / Out-of-Network)                                   | \$6,400<br>\$12,800   | \$5,000<br>\$10,000  | \$6,350 / \$19,050<br>\$12,700 / \$38,100<br><i>Includes Deductible</i> | \$7,000 / \$21,000<br>\$14,000 / \$42,000<br><i>Includes Deductible</i>          |
| <b>Physician Services (In-Network)</b><br>Well Adult / Well Child<br>Physician Office / Specialist Visit<br>X-Rays / Lab Diagnostics | 100%<br>\$30 copay / \$50 copay<br>100%   | 100%<br>\$30 / \$50 copay<br>100%                                | 100%<br>\$30 copay / \$50 copay<br>Deductible then 70%                  | 100%<br>Deductible then 80%<br>Deductible then 80%                               |
| <b>Emergency Room</b>  | \$250 copay +<br>Deductible then 70%  | \$200 copay  | \$150 copay +<br>Deductible then 70%                                    | Deductible then 80%  |
| <b>Urgent Care (In-Network)</b>  | \$30 copay  | \$30 copay   | \$30 copay  | Deductible then 80%  |
| <b>Prescription Drugs (In-Network)</b><br>Tier 1a / Tier 1b /<br>Tier 2 / Tier 3 / Tier 4  | <b>\$500 Deductible (3x Family) then Copays:</b><br>\$5 / \$20 / \$50 / \$75 /<br>Deductible then 30%,<br>up to \$250 Max | <b>Copays:</b><br>\$5 / \$20 / \$40 / \$60<br>30% to a \$250 Max | <b>Copays:</b><br>\$5 / \$20 / \$40 / \$60<br>30% to a \$250 Max        | <b>Deductible then Copays:</b><br>\$5 / \$15 / \$40 / \$60<br>30% to a \$250 Max |

| Bi-Weekly Contributions: | Priority HMO | Value HMO | PPO 3500 | High Deductible PPO with H.S.A |
|--------------------------|--------------|-----------|----------|--------------------------------|
| Employee Only            | \$130.24     | \$165.87  | \$238.17 | \$160.27                       |
| Employee & Spouse        | \$286.53     | \$364.92  | \$523.98 | \$352.59                       |
| Employee & Child(ren)    | \$234.43     | \$298.57  | \$428.71 | \$288.48                       |
| Family                   | \$403.74     | \$514.20  | \$738.33 | \$496.83                       |



# Dental Insurance | Anthem Blue Cross

## Preferred Provider Organization (PPO)

These dental plans allow the flexibility to select any dentist in-network or out-of-network. By staying in-network, the contract between your dentist and insurance carrier will make your annual benefit period maximum last longer.

Dental coverage focuses on preventive and diagnostic procedures in an effort to avoid more expensive services associated with dental disease and surgery. The type of service or procedure received determines the amount of coverage for each visit. Each type of service fits into a class of services according to complexity and cost.

### Preventive:

- Annual cleanings (2 per year)
- X-rays (1 per year)
- And more

### Basic:

- Fillings
- Root canals
- And more

### Major:

- Dentures/bridges/partials
- Extractions
- And more

| Dental Plan Details                 | PPO<br>In-Network / Out-of-Network |
|-------------------------------------|------------------------------------|
| Network Name                        | Dental Complete                    |
| Individual Deductible (Family = 3x) | \$50 / \$50                        |
| Office Visit Copay                  | None                               |
| Preventive Coinsurance              | 100% / 100%                        |
| Basic Coinsurance                   | 80% / 80%                          |
| Major Coinsurance                   | 50% / 50%                          |
| Annual Plan Maximum                 | \$2,000 / \$2,000                  |
| Orthodontia (up to age 19)          | 50% / 50%                          |
| Orthodontia Lifetime Maximum        | \$1,500 / \$1,500                  |

| Bi-Weekly Contributions: | You Pay |
|--------------------------|---------|
| Employee Only            | \$8.94  |
| Employee & Spouse        | \$18.23 |
| Employee & Child(ren)    | \$22.07 |
| Family                   | \$32.75 |



# Vision Insurance | Anthem Blue Cross

Vision insurance helps offset the costs of routine eye exams and also helps pay for vision correction eye wear, like eyeglasses and contacts, that may be prescribed by an eye-care provider. By accessing in-network vision providers, you're able to reap the benefit of true vision insurance coverage. You're eligible for an exam, frames, lenses or contact lenses every 12 months.

Out-of-network providers will merely offer you an allowance towards your vision services. Eye-care providers include many independent optical shops and national chains.

| Vision Plan Details:   | Frequency         | In-Network                        | Out-of-Network      |
|--|-------------------|-----------------------------------|---------------------|
| Network  | Blue View Vision  |                                   |                     |
| Eye Exam   | Every 12 months   | \$10 copay                        | \$42 max allowance  |
| Lenses<br>- Single vision<br>- Bifocal<br>- Trifocal<br>- Lenticular | Every 12 months*  | \$10 copay                        | Allowance varies    |
| Frames   | Every 12 months*  | \$130 allowance + 20% off balance | \$45 max allowance  |
| Elective Contacts  | Every 12 months** | \$130 allowance+ 15% off balance  | \$105 max allowance |

| Bi-Weekly Contributions: | You Pay |
|--------------------------|---------|
| Employee Only            | \$1.96  |
| Employee & Spouse        | \$3.92  |
| Employee & Child(ren)    | \$4.36  |
| Family                   | \$6.87  |

\*Vision benefit frequencies are based on the date of service within the policy year

\*\* You cannot get contacts and glasses in the same calendar year