Summary of Benefits 2015-16

The information in the booklet is only a brief description of the benefits and insurance plans, and is not a Summary Plan Description (SDP) for the plan.

For complete details on any benefit, refer to your member handbook, or the plan's benefit booklet. If there are any inconsistencies between the descriptions in this booklet and the insurance contracts, the insurance contract and plan agreements with contain legal, binding provisions and will prevail.

If you choose to enroll obtain enrollment forms from Human Resources.

At UNI Healthcare we know that, to succeed, we need staff who are committed to excellence. We acknowledge your important contributions to our success by providing a competitive total compensation package, consisting of pay, benefits and development opportunities.

What you need to do

- Review the benefits being offered to you and decide if you would like to enroll for the 2015-16 plan year. The plans being offered to you are:

  Medical -
  Anthem Blue Cross Bronze PPO
  Anthem Blue Cross Silver PPO
  Anthem Blue Cross Gold PPO

  Dental –
  Guardian DHMO
  Guardian DPPO

  Vision –
  Anthem Blue View Vision

- Complete the Employee Election Form along with the carrier Enrollment Forms included in your enrollment packet and return to Human Resources

Medical & Vision

Anthem Medical Benefits

Anthem BlueCross	Bronze PPO 5000/30%/6250	Silver PPO 2000/35%/6600	Gold PPO 500/20%/4500
Benefits below are in-network cost only. Please refer to your Summary of Benefits for out-of network cost.			
Calendar Year Deductible			
Individual Family	$5,000 $10,000	$2,000 $4,000	$500 $1,500
Out of Pocket Max Includes Deductible			
Individual Family	$6,250 $12,000	$6,600 $13,200	$4,500 $9,000
Physician Services			
Office Visits	$60/$70 for the first 3 visits, then applies to	$25 copay (deductible waived)	$30 copay (deductible waived)
Preventive Care	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)
Lab / X-Ray	30% after deductible	35% after deductible	20% after deductible
Hospital Services			
Inpatient Hospital	30% after deductible	35% after deductible	20% after deductible
Outpatient Surgery	30% after deductible	35% after deductible	20% after deductible
Emergency Room (Copay waived if admitted)	$300 copay after deductible	$300 copay + 35% after deductible	$200 copay + 20% after deductible
Urgent Care	$120 copay for the first 3 visits, then applies to deductible	$45 copay (deductible waived)	$60 copay (deductible waived)
Prescription Drugs:			
Generic	$15 copay after medical deductible	$15 copay	$15 copay
Preferred Brand	$50 copay after medical deductible	$35 copay	$35 copay after $250/$500 RX deductible
Non Preferred	$75 copay after medical deductible	$70 copay	$70 copay after $250/$500 RX deductible

Anthem Blue View Vision Benefits & Rates

Benefits	Frequency		In-Network	
Routine Eye Exam	Once every calendar year		$25 Copay	
Eyeglass Lenses	Once every two calendar years		$0	
Eyeglass Frames	Once every two calendar years		$120 allowance, then 20% balance	
Contact Lenses	Once every two calendar years		$115 allowance, then 15% off balance	
Monthly Rates	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Blue View Vision Cost	$7.19	$12.32	$12.02	$18.54

Medical Rates

Anthem Medical Monthly Rates

AGE	BRONZE PPO	SILVER PPO	GOLD PPO
0-18	$55.19	$100.14	$128.64
19-20	$55.19	$100.14	$128.64
21	$144.40	$215.18	$260.07
22	$144.40	$215.18	$260.07
23	$144.40	$215.18	$260.07
24	$144.40	$215.18	$260.07
25	$145.38	$216.44	$261.51
26	$150.27	$222.74	$268.71
27	$156.13	$230.31	$277.35
28	$165.66	$242.60	$291.40
29	$173.48	$252.69	$302.92
30	$177.39	$257.73	$308.68
31	$183.26	$265.29	$317.32
32	$189.13	$272.86	$325.96
33	$192.79	$277.59	$331.36
34	$196.70	$282.63	$337.12
35	$198.66	$285.15	$340.09
36	$200.61	$287.67	$342.89
37	$202.57	$290.19	$345.77
38	$204.52	$292.71	$348.65
39	$208.43	$297.76	$354.41
40	$212.34	$302.80	$360.17
41	$218.21	$310.36	$368.81

AGE	BRONZE PPO	SILVER PPO	GOLD PPO
42	$223.83	$317.61	$377.09
43	$231.65	$327.70	$388.61
44	$241.43	$340.31	$403.02
45	$252.91	$355.12	$419.94
46	$266.60	$372.77	$440.11
47	$282.00	$392.63	$462.79
48	$299.59	$415.32	$488.71
49	$316.95	$437.70	$514.28
50	$336.50	$462.91	$543.09
51	$355.81	$487.81	$571.53
52	$377.07	$515.23	$602.86
53	$398.58	$542.97	$634.54
54	$421.79	$572.91	$668.75
55	$445.01	$602.85	$702.96
56	$470.19	$635.31	$740.04
57	$495.60	$668.09	$777.49
58	$522.73	$703.08	$817.46
59	$536.17	$720.41	$837.26
60	$563.30	$755.40	$877.23
61	$586.76	$785.66	$911.80
62	$602.16	$805.51	$934.48
63	$621.47	$830.41	$962.93
64+	$633.20	$845.54	$980.21

Dental Coverage

Guardian Dental Benefits

Benefits	DHMO	DPPO	
	In-Network Only	In-Network	Out-of-network
Preventative Care			
Exam Cleaning	$0	100%	
Frequency	2 x year	Every 6 months	
Fluoride Treatments	$0	100%	
Limits	Under age 18	Under age 19	
Calendar Year Deductible			
	None	$50 Individual/ $150 Family	
Calendar Year Maximum			
	None	$1000 Per covered person	
Basic Care			
Anesthesia*	Not Covered	80%	
Fillings (one surface)	0	80%	
Perio Surgery	115	80%	
Periodontal Maintenance	15	80%	
Root Canal	$70-$140	80%	
Scaling & Root Planing	$25 Per quad	80%	
Simple Extractions	5	80%	
Surgical Extractions	$50-80	80%	
Major Care			
Bridges and Dentures	$110-$130	50%	
Inlays, Onlays, Veneers	$40-$80	50%	
Single Crowns	90	50%	
Orthodontia Limits:			
Adults and Children	$1,975-$2,175	Not covered	

Guardian Dental Monthly Rates

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
DHMO	$19.93	$39.33	$33.25	$55.17
DPPO	$60.33	$114.47	$134.96	$189.09

Questions?

For assistance with any benefit-related questions or claims issues, please contact our Insurance Broker directly at the telephone number or email below:

Barbara J. Ward, RHU, REBC
Member, Employee Benefits
Direct (805) 585-6194
bward@tolmanandwiker.com

TW Tolman & Wiker Insurance Services, LLC
Innovative Risk Advice Since 1923™

Benefits Enrollment

2015-16 Employee Benefits Election Form

EMPLOYEE INFORMATION

First and Last Name: _____ Date of Birth: _____

Address: _____ Date of Hire: _____

_____ SSN: _____

MEDICAL

Select your plan	Tier	Monthly Rates (See back for Monthly Medical Plan Rates)	Election
☐ Anthem BC BRONZE PPO Plan	Employee only	$	☐
☐ Anthem BC SILVER PPO Plan	Employee + Spouse	$	☐
☐ Anthem BC GOLD PPO Plan	Employee + Child(ren)	$	☐
	Family	$	☐

I wish to decline medical coverage offered to me by my employer. ☐

DENTAL

Carrier	Tier	Monthly Rates	Election
Guardian Dental DHMO Plan	Employee only	$19.93	☐
	Employee + Spouse	$39.33	☐
	Employee + 1 Child	$33.25	☐
	Family	$55.17	☐
Guardian Dental PPO Plan	Employee only	$60.33	☐
	Employee + Spouse	$114.47	☐
	Employee + 1 Child	$134.96	☐
	Family	$189.09	☐

I wish to decline dental coverage offered to me by my employer. ☐

VISION

Carrier	Tier	Monthly Rates	Election
Anthem BC Blue View Vision Plan	Employee only	$7.19	☐
	Employee + Spouse	$12.32	☐
	Employee + Child(ren)	$12.02	☐
	Family	$18.54	☐

I wish to decline vision coverage offered to me by my employer. ☐

I understand that by signing below, I authorize my employer to payroll deduct on a pre-tax basis the Per Pay Period contributions that correspond with my insurance elections noted above.

TOTAL DEDUCTIONS $ _____

Employee Signature: _____

Date: _____