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2023 Employee Benefits

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Table of Contents

Medical Plans

Kaiser	Anthem
The Kaiser HMO plans require members to obtain services from Kaiser Hospitals and medical facilities. Services outside of Kaiser are not covered with the exception of life-threatening emergencies. As a Kaiser member you should choose a Kaiser Permanente facility close to your home or work as it is where you will receive most of your care	The Anthem plans are PPO (Preferred Provider Organization) plans. This allows the greatest amount of flexibility for members. As a member you are free to see any physician. If you choose a provider within the PPO network you will have a lower out of pocket expensive. Certain services may require you to satisfy a deductible, co-payment or co-insurance.
Can I choose my own doctor within my selected Kaiser facility? Yes, the choice is yours just call the facility in which you plan to receive care.	**What if I need to see a specialist?** You may go directly to any specialist; however, depending on procedures needed prior authorization may be necessary.
What if I need care urgently but it's not an emergency? Kaiser provides same day appointments at most locations.	**What if my doctor is not an In-Network Provider?** Services will be covered based on your plan selection. This means your services will be paid at the Out-of-Network level. Review your Summary of Benefits for specific information.
How is the emergency care covered within Kaiser? If you have an emergency, call 911 or go to the nearest hospital. When you have an emergency, Kaiser covers the care from Kaiser providers and non-Kaiser providers anywhere in the world. The same level of benefits is available for emergency care.	**How is emergency care covered?** The same level of benefits is available for emergency care in and out of network. However, the member may be required to transfer to an in-network facility once able.

Kaiser

Plan Options

Services	Bronze HMO A	Silver HMO C (Base Plan)	Gold HMO B
Deductible **- Individual** **- Family**	$6300 $12600	$2,500 $5,000	$250 $500
Out of Pocket Max **-Individual** **- Family**	$8200 $16400	$8,750 $17,500	$7,800 $15,600
Coinsurance **Percentage Paid by the Employee**	40%	40%	None
Physician Visit	DED waived 1st 3 Visits PCP: $65 Specialist $95	PCP: $55 Specialist $90	PCP: $35 Specialist $55
Inpatient	40% Coinsurance	40% Coinsurance	$600/Day
Outpatient	40% Coinsurance	40% Coinsurance	$335/Procedure
Labs & Imaging	Lab: $40 X-Ray: 40% after ded Radiology: 40% after ded	Lab: $55 X-Ray: $90 Radiology: $300 after ded	Lab: $35 X-Ray: $55 Radiology: $250
Prescription Drugs	**Prescription Deductible:** $500 Generic: $18 after ded Brand: 40% after ded	**Prescription Deductible:** $370 Generic: $19 Brand: $85	**Prescription Deductible:** None Generic: $15 Brand: $40
Urgent Care	DED waived 1st 3 Visits $65	$55	$35
Emergency Room	40% after ded	30% after ded	$250 (Waived if Admitted)
Ambulance	40% after ded	30% after ded	$250

Anthem

Silver Options

Services	Silver Select PPO B	Silver PPO C
Deductible **- Individual** **- Family**	 $1,700 $3,400	 $1,700 $3,400
Out of Pocket Max **-Individual** **- Family**	 $9,100 $18,200	 $9,100 $18,200
Coinsurance **Percentage Paid by the Employee**	40%	40%
Physician Visit	PCP: $50 Specialist: $95	PCP: $50 Specialist: $95
Inpatient	40% after ded	40% after ded
Outpatient	$200/Procedure + 40%	$200/Procedure + 40%
Labs & Imaging	$20	$20
Prescription Drugs	**Brand Name Deductible:** $300 Generic: $15/$20 Preferred Brand: $70/$80 Non-Preferred: $110/$120	**Brand Name Deductible:** $300 Generic: $15/$20 Preferred Brand: $70/$80 Non-Preferred: $110/$120
Urgent Care	$50	$50
Emergency Room	$300 +40% after ded (Waived if Admitted)	$300 +40% after ded (Waived if Admitted)
Ambulance	40% after ded	40% after ded

Anthem

Gold Options

Services	Gold Select PPO B	Gold PPO E
Deductible **- Individual** **- Family**	 $1,000 $3,000	 $500 $1,500
Out of Pocket Max **-Individual** **- Family**	 $7,800 $15,600	 $7,700 $15,400
Coinsurance **Percentage Paid by the Employee**	25%	20%
Physician Visit	PCP: $25 Specialist: $50	PCP: $30 Specialist: $60
Inpatient	25% after ded	40% after ded
Outpatient	$200/Procedure + 25%	$200/Procedure + 20%
Labs & Imaging	$15	$15
Prescription Drugs	**Brand Name Deductible:** $250 Generic: $10/$20 Preferred Brand: $50/$60 Non-Preferred: $90/$100	**Brand Name Deductible:** None Generic: $10/$20 Preferred Brand: $50/$60 Non-Preferred: $90/$100
Urgent Care	$25	$30
Emergency Room	$250 + 20% after ded (Waived if Admitted)	$250 + 20% after ded (Waived if Admitted)
Ambulance	20% after ded	20% after ded

Humana

Dental Plan

Services	Unlimited Traditional Dental	
	In Network	Out of Network
Deductible - Individual - Family	$50 $150	$50 $150
Annual Maximum	Unlimited	Unlimited
Preventative	Fully Covered	
Basic	20%	20%
Major	50%	50%
Helpful Information		
If you use an in-network provider you will pay a portion of the negotiated charge. Out-of-network services you will be responsible for the difference between the allowed amount and actual cost		

Humana

Vision Plan

Services		Vision 130	
Benefit	Frequency	In Network	Out of Network
Exam	Once/12 Months	$10 Copay	Allowance up to $30
Eyeglass Lens - **Single** - **Bifocal** - **Trifocal** - **Lenticular**	One Pair/12 Months	$55	Allowance of Up to $25 Up to $40 Up to $60 Up to $100
Frames	One/12 Months	$130 Allowance 20% off remaining balance	Allowance of up to $65
Contacts **(Medically Necessary)**	One Purchase/ 12 Months	Covered After Copay	Allowance up to $200
Contacts **(Elective)**		$130 Allowance 15% off remaining balance	Allowance up to $104
Helpful Information			
. Contact lenses are in lieu of frames and lens. A member cannot receive both benefits within the same 12 month period.			

Humana

Life Insurance

Benefit	Life & AD&D
Life Benefit	$15,000
Accelerated Death	50% of Life Benefit
Accidental Death and Dismemberment	$15,000
Partial Bodily Injury	50% Life Benefit

Holman Group

Employee Assistance Program

Service
• **Toll Free Crisis Line:** Nationwide number staffed by licensed therapists available to help in a crisis. • **Free Legal Consultation:** 30 Minute phone consultation with licensed attorney • **Free Financial Consultation**: 60 Minute phone consult with financial management experts. • **Community Referrals:** For Childcare, elder assistance, support groups, chemical dependency groups and more. • **Webinars:** Available weekly on topics such as, nutrition, wellness, stress management, goals, etc. Please refer to the Ease portal for details about additional services.
Available to all eligible employees on the 1st of the month following 60 days. Benefits also extend to dependents and household members regardless of enrollment status.

References

Company	Contact Information
PCB Insurance Benefit Broker Dave Villar | President Bryan Villar | VP of Employee Benefits Abigail Byrd | Account Manager	**Phone:** 408-847-100 **Fax:** 408-848-2314 dave@pcb-insurance.com bryan@pcb-insurance.com abby@pcb-insurance.com
California Choice Group: 43416	1-800-558-8003 www.calchoice.com
Anthem	1-866-461-3585 www.anthem.com
Kaiser	1-800-464-4000 www.kp.org
Humana Group: 864750	1-800-457-4708 www.humana.com
Holman Group Username: SSC Password: SSC7122	1-800-321-2843 www.holmangroup.com

Coinsurance	Also known as Cost-Sharing is the portion of covered cost which you are financially responsible for. Not including copays or deductibles
Deductible	The out of pocket amount you must pay each year before the plan pays for eligible benefits
In Network Provider	A provider who is contracted with a health care plan (medical dental or vision) and agreed to certain rates in most cases you pay less and receive a higher benefit when you use in network providers
Out of Pocket Maximum	This is the threshold on your out of pocket expense for the year once you reach this amount your plan will cover the rest of your qualified expenses.