



# 2024 Employee Benefits



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## Medical Plans

Kaiser	Anthem
<p>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</p>	<p>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 expense. Certain services may require you to satisfy a deductible, co-payment or co-insurance.</p>
<p><b>Can I choose my own doctor within my selected Kaiser facility?</b> Yes, the choice is yours just call the facility in which you plan to receive care.</p>	<p><b>What if I need to see a specialist?</b> You may go directly to any specialist; however, depending on procedures needed prior authorization may be necessary.</p>
<p><b>What if I need care urgently but it's not an emergency?</b> Kaiser provides same day appointments at most locations.</p>	<p><b>What if my doctor is not an In-Network Provider?</b> 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.</p>
<p><b>How is the emergency care covered within Kaiser?</b> 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.</p>	<p><b>How is emergency care covered?</b> 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.</p>

# Kaiser

## Plan Options

Services	Bronze HMO A	Silver HMO C (Base Plan)	Gold HMO B
<b>Deductible</b> - Individual - Family	\$6300 \$12600	\$2,500 \$5,000	\$250 \$500
<b>Out of Pocket Max</b> - Individual - Family	\$9100 \$18200	\$8,750 \$17,500	\$7,800 \$15,600
<b>Coinsurance</b> Percentage Paid by the Employee	40%	35%	20%
<b>Physician Visit</b>	DED waived 1 <sup>st</sup> 3 Visits PCP: \$65 Specialist \$95	PCP: \$55 Specialist \$90	PCP: \$35 Specialist \$55
<b>Inpatient</b>	40% Coinsurance	35% Coinsurance	\$600/Day
<b>Outpatient</b>	40% Coinsurance	35% Coinsurance	\$335 after ded
<b>Labs &amp; Imaging</b>	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
<b>Prescription Drugs</b>	<b>Prescription Deductible:</b> \$500 Generic: \$17 after ded Brand: 40% after ded	<b>Prescription Deductible:</b> \$300 Generic: \$19 Brand: \$85	<b>Prescription Deductible:</b> None Generic: \$15 Brand: \$40
<b>Urgent Care</b>	DED waived 1 <sup>st</sup> 3 Visits \$60	\$55	\$35
<b>Emergency Room</b>	40% after ded	35% after ded	\$250 (Waived if Admitted)
<b>Ambulance</b>	40% after ded	35% after ded	\$250 after ded



# Anthem

## Silver Options

Services	Silver Select PPO B	Silver PPO C
<b>Deductible</b> - Individual - Family	\$1,700 \$3,400	\$1,700 \$3,400
<b>Out of Pocket Max</b> -Individual - Family	\$9,100 \$18,200	\$9,100 \$18,200
<b>Coinsurance</b> Percentage Paid by the Employee	40%	40%
<b>Physician Visit</b>	PCP: \$50 Specialist: \$95	PCP: \$50 Specialist: \$95
<b>Inpatient</b>	40% after ded	40% after ded
<b>Outpatient</b>	\$250/Procedure + 40% after ded	\$250/Procedure + 40% after ded
<b>Labs &amp; Imaging</b>	\$20	\$20
<b>Prescription Drugs</b>	<b>Brand Name Deductible:</b> \$300 Generic: \$15/\$20 Preferred Brand: \$70/\$80 Non-Preferred: \$110/\$120	<b>Brand Name Deductible:</b> \$300 Generic: \$15/\$20 Preferred Brand: \$70/\$80 Non-Preferred: \$110/\$120
<b>Urgent Care</b>	\$50	\$50
<b>Emergency Room</b>	\$300 +40% after ded (Waived if Admitted)	\$300 +40% after ded (Waived if Admitted)
<b>Ambulance</b>	40% after ded	40% after ded

# Anthem

## Gold Options

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

# Humana

## Dental Plan

Services	Unlimited Traditional Dental	
	In Network	Out of Network
<b>Deductible</b> - Individual - Family	\$50 \$150	\$50 \$150
<b>Annual Maximum</b>	Unlimited	Unlimited
<b>Preventative</b>	Fully Covered	
<b>Basic</b>	20%	20%
<b>Major</b>	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
<b>Exam</b>	Once/12 Months	\$10 Copay	Allowance up to \$30
<b>Eyeglass Lens</b> - Single - Bifocal - Trifocal - Lenticular	One Pair/12 Months	\$55	Allowance of Up to \$25 Up to \$40 Up to \$60 Up to \$100
<b>Frames</b>	One/12 Months	\$130 Allowance 20% off remaining balance	Allowance of up to \$65
<b>Contacts</b> (Medically Necessary)	One Purchase/ 12 Months	Covered After Copay	Allowance up to \$200
<b>Contacts</b> (Elective)		\$130 Allowance 15% off remaining balance	Allowance up to \$104
<b>Helpful Information</b>			
. Contact lenses are in lieu of frames and lens. A member cannot receive both benefits within the same 12 month period.			



# Humana

## Life Insurance

<b>Benefit</b>	<b>Life &amp; AD&amp;D</b>
<b>Life Benefit</b>	\$15,000
<b>Accelerated Death</b>	50% of Life Benefit
<b>Accidental Death and Dismemberment</b>	\$15,000
<b>Partial Bodily Injury</b>	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 1<sup>st</sup> of the month following 60 days. Benefits also extend to dependents and household members regardless of enrollment status.

## References

Company	Contact Information
<b>PCB Insurance</b> Benefit Broker Dave Villar   President Bryan Villar   VP of Employee Benefits Brandon Munoz   Client Services	<b>Phone:</b> 408-847-1000 <b>Fax:</b> 408-848-2314 <a href="mailto:dave@pcb-insurance.com">dave@pcb-insurance.com</a> <a href="mailto:bryan@pcb-insurance.com">bryan@pcb-insurance.com</a> <a href="mailto:bmunoz@pcb-insurance.com">bmunoz@pcb-insurance.com</a>
<b>California Choice</b> Group: 43416	1-800-558-8003 <a href="http://www.calchoice.com">www.calchoice.com</a>
<b>Anthem</b>	1-866-461-3585 <a href="http://www.anthem.com">www.anthem.com</a>
<b>Kaiser</b>	1-800-464-4000 <a href="http://www.kp.org">www.kp.org</a>
<b>Humana</b> Group: 864750	1-800-457-4708 <a href="http://www.humana.com">www.humana.com</a>
<b>Holman Group</b> Username: SSC Password: SSC7122	1-800-321-2843 <a href="http://www.holmangroup.com">www.holmangroup.com</a>

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.