Benefits Marketing Presentation

Prepared for:

San Bernardino County Employees' Retirement Association

Recommendations and Package Options

PACE Options

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Important

This proposal is based upon census data and information provided by your company. Final rates may be adjusted to reflect the overall risk of the group, as determined through medical underwriting, based on the final enrollment data required prior to coverage being in force.

This proposal does not pre-empt or take the place of the actual insurance contracts. For further details, refer to the actual proposal and/or insurance contract. In the event you should have specific questions concerning the program or its coverage, please contact our office for assistance.

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Proposed Benefit Package

Effective: 10/1/2022

	Current	Proposed Package	
Signature HMO	$ 40,455.24	PACE Anthem HMO $10	$ 47,868.09
Access+ HMO	$ 5,618.04	PACE Anthem HMO $35	$ 7,108.84
Kaiser HMO $10	$ 20,874.51	PACE Kaiser $10	$ 20,804.82
Kaiser Choice HMO	$ 4,022.96	PACE Kaiser $25	$ 4,009.89
Blue Shield PPO	$ 1,247.26	PACE Anthem PPO 250	$ 881.93
Dental PPO	$ 4,750.08	Dental PPO MDP	$ 4,669.44
Dental HMO	$ 671.60	Dental HMO MDP	$ 620.40
Vision	$ 428.94	Vision EyeMed (Standard)	$ 824.90
Group Life /AD&D	$ 212.24	Group Life/AD&D (Standard)	$ 645.00
Disability	$ 7,305.48	Disability (Standard)	$ 4,788.21
EAP	$ 100.00	EAP Standard (6 visit)	$ 17.00
COBRA	$ -	Igoe	$ 275.00
FMLA	$ 237.32	Standard FMLA	$ 204.00
FSA	$ -	Igoe	$ 333.20
Monthly Premium	**$85,924**	**$93,051**	
Annual Premium	**$1,031,084**	**$1,116,609**	
% Change Over Current		**8.29%**	
$ Change Over Current		**$85,525**	

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Signature HMO

Effective: October 1, 2022

	Current	Proposed
Carrier Name	**Blue Shield**	**Anthem (PACE)**
Plan Name	Signature HMO	HMO $10
Rate Guarantee	July 2023	December 2023
General Plan Information		
Annual Deductible (Individual)	$0	$0
Annual Deductible (Family)	$0	$0
Coinsurance	N/A	N/A
Office Visit/Exam Copay	$10 copay (Level I), $30 (Level 2)	$10 copay
Outpatient Specialist Visit Copay	$10 copay (Level I), $30 (Level 2)	$30 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$2,000
Annual Out-of-Pocket Limit/Family	$3,000	$4,000
Outpatient Services		
Preventive Services		
Most ACA-Mandated Preventive Care Services	100%	100%
Diagnostic X-Ray and Lab Tests	100%	100%
Maternity Care		
Pregnancy and Maternity Pre-Natal Care	100%	$10 copay
Inpatient Hospital Services		
Inpatient Hospitalization	100%	$250 copay/admit
Surgical Services		
Outpatient Facility Charge	100%	$125 copay/admit
Emergency Services		
Emergency Room Copay (waived if admitted)	$50 copay	$100 copay
Ambulance		
Air & Ground	100%	$100 copay
Urgent Care		
Urgent Care Facility	$10 copay (Level I), $30 (Level 2)	$10 copay
Mental Health & Substance Abuse		
Inpatient Care	100%	$250 copay/admit
Outpatient Care	$10 copay (Level I), $30 (Level 2)	$10 copay

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Signature HMO

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Blue Shield**	**Anthem (PACE)**
Plan Name		Signature HMO	HMO $10
Prescription Drug Benefits			
Rx Deductible		$0	$0
Rx Annual Out-of-Pocket Limit/Individual		Combined with Medical OOP	Included in Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		Combined with Medical OOP	Included in Medical OOP
Generic		$5 copay	$5 copay (1a) - $15 copay (1b)
Brand (Formulary/Preferred)		$10 copay	$30 copay
Brand (Non-Formulary/Non-preferred)		$25 copay	$50 copay
Specialty		$10 copay	30% coinsurance up to $250
Number of Days Supply		30 days	30 days
Mail Order			
Generic		$10 copay	$12.50 (1a) - $37.50 (1b)
Brand (Formulary/Preferred)		$20 copay	$90 copay
Brand (Non-Formulary/Non-preferred)		$50 copay	$150 copay
Number of Days Supply for Mail Order		90 days	90 days
Other Services and Supplies			
Durable Medical Equipment		100%	80%
Home Health Care		100%	$10 copay (30 visits/year)
Skilled Nursing or Extended Care Facility		100%	100% (100 days/year)
Hospice Care		100%	100%
Chiropractic Services		Not covered	$10 copay (30 visits/year)
Acupuncture		Not covered	$10 copay (30 visits/year)
Outpatient Rehabilitative Therapy Services			
Physical, Occupational, & Speech Therapy		$0 first 3 visits, then $10/visit	$10 copay - $30 outpatient
Rate Structure	**Subs**		
Employee Only	14	$671.32	$761.61
Employee + 1	2	$1,338.39	$1,590.30
Employee + Family	15	$1,892.00	$2,268.33
Monthly Premium		**$40,455.24**	**$47,868.09**
Annual Premium		**$485,462.90**	**$574,417.08**
% Change Over Current			**18.32%**
$ Change Over Current			**$88,954.18**

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Access+ HMO

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Blue Shield**	**Anthem (PACE)**
Plan Name		Access+ HMO	HMO $35
Rate Guarantee		July 2023	December 2023
General Plan Information			
Annual Deductible (Individual)		$0	$0
Annual Deductible (Family)		$0	$0
Coinsurance		N/A	N/A
Office Visit/Exam Copay		$40 copay	$35 copay
Outpatient Specialist Visit Copay		$50 copay	$45 copay
Annual Out-of-Pocket Limit/Individual		$3,500	$2,500
Annual Out-of-Pocket Limit/Family		$7,000	$5,000
Outpatient Services			
Preventive Services			
Most ACA-Mandated Preventive Care Services		100%	100%
Diagnostic X-Ray and Lab Tests		60%	100%
Maternity Care			
Pregnancy and Maternity Pre-Natal Care		100%	$35 copay
Inpatient Hospital Services			
Inpatient Hospitalization		$100 copay + 80%	$750 copay/admit
Surgical Services			
Outpatient Facility Charge		60%	$375 copay/admit
Emergency Services			
Emergency Room Copay (waived if admitted)		$50 copay	$100 copay
Ambulance			
Air & Ground		100%	$100 copay
Urgent Care			
Urgent Care Facility		$40 copay	$35 copay
Mental Health & Substance Abuse			
Inpatient Care		$100 copay + 80%	$750 copay/admit
Outpatient Care		$40 copay	$35 copay

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Access+ HMO

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Blue Shield**	**Anthem (PACE)**
Plan Name		Access+ HMO	HMO $35
Prescription Drug Benefits			
Rx Deductible		$0	$0
Rx Annual Out-of-Pocket Limit/Individual		Combined with Medical OOP	Included in Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		Combined with Medical OOP	Included in Medical OOP
Generic		$5 copay	$5 copay (1a) · $15 copay (1b)
Brand (Formulary/Preferred)		$10 copay	$30 copay
Brand (Non-Formulary/Non-preferred)		$25 copay	$50 copay
Specialty		20% coinsurance ($250 max/Rx)	30% coinsurance up to $250
Number of Days Supply		30 days	30 days
Mail Order			
Generic		$10 copay	$12.50 (1a) · $37.50 (1b)
Brand (Formulary/Preferred)		$20 copay	$90 copay
Brand (Non-Formulary/Non-preferred)		$50 copay	$150 copay
Number of Days Supply for Mail Order		90 days	90 days
Other Services and Supplies			
Durable Medical Equipment		60%	80%
Home Health Care		100% (100 visits/year)	$10 copay (30 visits/year)
Skilled Nursing or Extended Care Facility		100% (100 days/year)	100% (100 days/year)
Hospice Care		100%	100%
Chiropractic Services		Not covered	$10 copay (30 visits/year)
Acupuncture		Not covered	$10 copay (30 visits/year)
Outpatient Rehabilitative Therapy Services			
Physical, Occupational, & Speech Therapy		$40 copay	$35 copay · $45 outpatient
Rate Structure	**Subs**		
Employee Only	4	$583.20	$714.18
Employee + 1	0	$1,162.14	$1,490.71
Employee + Family	2	$1,642.62	$2,126.06
Monthly Premium		**$5,618.04**	**$7,108.84**
Annual Premium		**$67,416.44**	**$85,306.08**
% Change Over Current			**26.54%**
$ Change Over Current			**$17,889.64**

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PPO Comparison

Effective: October 1, 2022

		Current		Proposed	
Carrier Name		Blue Shield		PACE Anthem Blue Cross	
Plan Name		Custom PPO $250		PPO 250	
Rate Guarantee		July 2023		December 2023	
		Blue Shield	Non-PPO	Anthem Blue Cross	Non-PPO
General Plan Information		**In Network**	**Out of Network**	**In Network**	**Out of Network**
Annual Deductible/Individual		$250		$250	
Annual Deductible/Family		$500		$750	
Coinsurance		80%	70%	90%	70%
Office Visit/Exam		$10 copay	70%	$20 copay (deductible waived)	70%
Outpatient Specialist Visit		$10 copay	70%	$20 copay (deductible waived)	70%
Annual Out-of-Pocket Limit/Individual		$1,750	$2,250	$2,500	$6,500
Annual Out-of-Pocket Limit/Family		$3,500	$4,500	$5,000	$13,000
Outpatient Services					
Preventive Services					
Most ACA-Mandated Preventive Care Services		100% (deductible waived)	70%	100% (deductible waived)	70%
Diagnostic X-Ray and Lab Tests		80%	70%	100% (deductible waived)	70%
Maternity Care					
Pregnancy and Maternity Pre-Natal Care		80%	70%	$20 copay (deductible waived)	70%
Inpatient Hospital Services					
Inpatient Hospitalization		80%	70%	90%	70% ($1,000/day non-emergency)
Surgical Services					
Outpatient Facility Charge		80%	70%	90%	70% ($350 max/admit)
Emergency Services					
Emergency Room Copay (Waived if Admitted)		$50 copay	$50 copay	$150 copay	$150 copay
Ambulance					
Air & Ground		80%	80%	90%	90% (70% non-emergency)
Urgent Care					
Urgent Care Facility		$10 copay	70%	$20 copay (deductible waived)	70%
Mental Health & Substance Abuse Benefits					
Inpatient Care		80%	70%	90%	70% ($1,000/day non-emergency)
Outpatient Care		$10 copay	70%	$20 copay (deductible waived)	70%

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PPO Comparison

Effective: October 1, 2022

		Current		Proposed	
Carrier Name		Blue Shield		PACE Anthem Blue Cross	
Plan Name		Custom PPO $250		PPO 250	
Rate Guarantee		July 2023		December 2023	
		Blue Shield	**Non-PPO**	**Anthem Blue Cross**	**Non-PPO**
Prescription Drug Benefits					
Rx Deductible		$0		$0	$0
Rx Annual Out-of-Pocket Limit/Individual		Combined with Medical OOP	Combined with Medical OOP	Included in Medical OOP	Included in Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		Combined with Medical OOP	Combined with Medical OOP	Included in Medical OOP	Included in Medical OOP
Generic		$15 copay	$15 copay + 25% coinsurance	$10 copay	$10 copay + 50%
Brand (Formulary/Preferred)		$30 copay	$30 copay + 25% coinsurance	$30 copay	$30 copay + 50%
Brand (Non-Formulary/Non-preferred)		$30 copay	$30 copay + 25% coinsurance	$50 copay	$50 copay + 50%
Specialty		$15 copay	Not covered	30% coinsurance up to $150	Not covered
Number of Days Supply		30 days	30 days	30 days	30 days
Mail Order					
Generic		$30 copay	Not covered	$10 copay	Not covered
Brand (Formulary/Preferred)		$60 copay	Not covered	$60 copay	Not covered
Brand (Non-Formulary/Non-preferred)		$60 copay	Not covered	$100 copay	Not covered
Number of Days Supply for Mail Order		90 days	N/A	90 days	N/A
Other Services and Supplies					
Durable Medical Equipment		80%	70%	90%	70%
Home Health Care		80% (100 visits/year)	Not covered	90% (100 visits/year)	70% (100 visits/year)
Skilled Nursing or Extended Care Facility		80% (100 days/year)	70% (100 days/year)	90% (100 days/year)	70% (100 days/year)
Hospice Care		100%	Not covered	100% (deductible waived)	70%
Chiropractic Services		80% (20 visits/year)	70% (20 visits/year)	$20 (ded waived); 30 visits/year	70% (30 visits/year)
Acupuncture		80% (30 visits/year)	70% (30 visits/year)	$20 (ded waived); 20 visits/year	70% (20 visits/year)
Outpatient Rehabilitative Therapy Services					
Physical & Occupational		80%	70%	90%	70%
Speech		80%	70%	90%	70%
Rate Structure	**Subs**				
Employee Only	1	$1,247.26		$881.93	
Employee + 1	0	$2,537.41		$1,763.86	
Employee + Family	0	$3,936.03		$2,733.99	
Monthly Premium		**$1,247.26**		**$881.93**	
Annual Premium		**$14,967.16**		**$10,583.16**	
% Change Over Current				**-29.29%**	
$ Change Over Current				**-$4,384.00**	

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Kaiser Comparison

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Kaiser**	**Kaiser (PACE)**
Plan Name		HMO $10	PACE HMO $10
Rate Guarantee		July 2023	December 2023
General Plan Information			
Annual Deductible (Individual)		$0	$0
Annual Deductible (Family)		$0	$0
Coinsurance		N/A	N/A
Office Visit/Exam Copay		$10 copay	$10 copay
Outpatient Specialist Visit Copay		$10 copay	$10 copay
Annual Out-of-Pocket Limit/Individual		$1,500	$1,500
Annual Out-of-Pocket Limit/Family		$3,000	$3,000
Outpatient Services			
Preventive Services			
Most ACA-Mandated Preventive Care Services		100%	100%
Diagnostic X-Ray and Lab Tests		100%	100%
Maternity Care			
Pregnancy and Maternity Pre-Natal Care		100%	100%
Inpatient Hospital Services			
Inpatient Hospitalization		100%	100%
Surgical Services			
Outpatient Facility Charge		$10 copay/procedure	$10 copay/procedure
Emergency Services			
Emergency Room Copay (waived if admitted)		$50 copay	$100 Copay
Ambulance			
Air & Ground		100%	100%
Urgent Care			
Urgent Care Facility		$10 copay	$10 copay
Mental Health & Substance Abuse			
Inpatient Care		100%	100%
Outpatient Care		$10 copay	$10 copay

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Kaiser Comparison

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Kaiser**	**Kaiser (PACE)**
Plan Name		HMO $10	PACE HMO $10
Prescription Drug Benefits			
Rx Deductible		$0	$0
Rx Annual Out-of-Pocket Limit/Individual		Combined with Medical OOP	Combined with Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		Combined with Medical OOP	Combined with Medical OOP
Generic		$10 copay	$10 copay
Brand (Formulary/Preferred)		$15 copay	$20 copay
Brand (Non-Formulary/Non-preferred)		Not covered	Not covered
Specialty		$15 copay	20% up to $150/Rx
Number of Days Supply		100 days	30 days
Mail Order			
Generic		$10 copay	$20 copay
Brand (Formulary/Preferred)		$15 copay	$40 copay
Brand (Non-Formulary/Non-preferred)		Not covered	Not covered
Number of Days Supply for Mail Order		100 days	100 days
Other Services and Supplies			
Durable Medical Equipment		100%	100%
Home Health Care		100% (100 visits/year)	100% (100 visits/year)
Skilled Nursing or Extended Care Facility		100% (100 days/year)	100% (100 days/year)
Hospice Care		100%	100%
Chiropractic Services		Not covered	$10 (30 visits/year)
Acupuncture		Not covered	Not covered
Outpatient Rehabilitative Therapy Services			
Physical, Occupational, & Speech Therapy		$10 copay	$10 copay
Rate Structure	**Subs**		
Employee Only	7	$698.32	$693.96
Employee + 1	3	$1,392.28	$1,387.92
Employee + Family	6	$1,968.24	$1,963.89
Monthly Premium		**$20,874.51**	**$20,804.82**
Annual Premium		**$250,494.14**	**$249,657.84**
% Change Over Current			**-0.33%**
$ Change Over Current			**-$836.30**

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Kaiser Comparison

Effective: October 1, 2022

	Current	Proposed
Carrier Name	**Kaiser**	**Kaiser (PACE)**
Plan Name	Choice HMO	PACE HMO $25
Rate Guarantee	July 2023	December 2023
General Plan Information		
Annual Deductible (Individual)	$0	$0
Annual Deductible (Family)	$0	$0
Coinsurance	N/A	N/A
Office Visit/Exam Copay	$40 copay	$25 copay
Outpatient Specialist Visit Copay	$50 copay	$25 copay
Annual Out-of-Pocket Limit/Individual	$3,500	$1,500
Annual Out-of-Pocket Limit/Family	$7,000	$3,000
Outpatient Services		
Preventive Services		
Most ACA-Mandated Preventive Care Services	100%	100%
Diagnostic X-Ray and Lab Tests	$10 copay	100%
Maternity Care		
Pregnancy and Maternity Pre-Natal Care	100%	100%
Inpatient Hospital Services		
Inpatient Hospitalization	$500/day	$250 per admission
Surgical Services		
Outpatient Facility Charge	$250 copay/procedure	$25 Copay
Emergency Services		
Emergency Room Copay (waived if admitted)	$150 copay	$100 copay
Ambulance		
Air & Ground	$150 per trip	100%
Urgent Care		
Urgent Care Facility	$40 copay	$25 copay
Mental Health & Substance Abuse		
Inpatient Care	$500/day	$250 per admission
Outpatient Care	$40 copay ($20 outpatient)	$25 copay

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Kaiser Comparison

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Kaiser**	**Kaiser (PACE)**
Plan Name		Choice HMO	PACE HMO $25
Prescription Drug Benefits			
Rx Deductible		$0	$0
Rx Annual Out-of-Pocket Limit/Individual		Combined with Medical OOP	Combined with Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		Combined with Medical OOP	Combined with Medical OOP
Generic		$15 copay	$15 copay
Brand (Formulary/Preferred)		$35 copay	$30 copay
Brand (Non-Formulary/Non-preferred)		Not covered	Not covered
Specialty		30% coinsurance ($200 max/Rx)	30% coinsurance ($150 max/Rx)
Number of Days Supply		30 days	30 days
Mail Order			
Generic		$30 copay	$30 copay
Brand (Formulary/Preferred)		$70 copay	$60 copay
Brand (Non-Formulary/Non-preferred)		Not covered	Not covered
Number of Days Supply for Mail Order		100 days	100 days
Other Services and Supplies			
Durable Medical Equipment		50%	100%
Home Health Care		100% (100 visits/year)	100% (100 visits/year)
Skilled Nursing or Extended Care Facility		100% (100 days/year)	100% (100 days/year)
Hospice Care		100%	100%
Chiropractic Services		Not covered	$10 (30 visits/year)
Acupuncture		Not covered	Not covered
Outpatient Rehabilitative Therapy Services			
Physical, Occupational, & Speech Therapy		$40 copay	$25 copay
Rate Structure	**Subs**		***Breakaway Rates***
Employee Only	1	$606.43	$602.07
Employee + 1	0	$1,208.50	$1,204.15
Employee + Family	2	$1,708.27	$1,703.91
Monthly Premium		**$4,022.96**	**$4,009.89**
Annual Premium		**$48,275.50**	**$48,118.68**
% Change Over Current			**-0.32%**
$ Change Over Current			**-$156.82**

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Dental PPO

Effective: October 1, 2022

		Current		Proposed	
Carrier Name		Delta Dental		Delta Dental (MDP)	
Rate Guarantee		July 2023		July 2023	
Plan Name		DPPO		Shelf Plan 1 w/Ortho E	
Network		Delta	Non-PPO	Delta	Non-PPO
General Plan Information					
Annual Deductible/Individual		$0	$0	$0	$75
Annual Deductible/Family		$0	$0	$0	$225
Annual Plan Maximum		$1,700		$2,000	$1,500
Waiting Period		None		None	
Out-of-Network Reimbursement		N/A	TBD	N/A	50th% UCR
Covered Services					
Diagnostic and Preventive					
Diagnostic and Preventive		100%	100%	100%	100%
Sealants		90%	90%	100%	100%
Basic Services					
Basic		100%	90%	90%	80%
Endodontic Treatment		100%	90%	90%	80%
Periodontic Treatment		90%	90%	90%	80%
Major Services					
Major		75%	70%	80%	60%
Prosthodontics		75%	70%	80%	50%
Implants		Not covered	Not covered	Included	Included
Orthodontia Services					
Lifetime Maximum		$1,700	$1,700	$2,000	$2,000
Orthodontia (Child) - to age 26		50%	50%	50%	50%
Orthodontia (Adult)		50%	50%	50%	50%
Rate Structure	**Subs**				
Employee Only	16	$50.25		$51.54	
Employee + 1	8	$93.51		$100.50	
Employee + Family	20	$159.90		$152.04	
Monthly Premium		**$4,750.08**		**$4,669.44**	
Annual Premium		**$57,000.96**		**$56,033.28**	
% Change Over Current				**-1.70%**	
$ Change Over Current				**-$967.68**	

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Dental HMO

Effective: October 1, 2022

			Current	Option 2
Carrier Name			Delta Dental	Delta Dental
Rate Guarantee			July 2025	July 2023
Plan Name			CAD90	11B
Diagnostic and Preventive Services				
D0150	Comprehensive Oral Evaluation		$0	$0
D1510	Space Maintainers		$15	$25
Restorative Services				
D2392	Composite Filling (two surfaces, posterior)		$55	$65
Endontics				
D3220	Therapeutic Pulpotomy		$0	$0
D3310	Root Canal Therapy - Anterior		$20	$55
D3320	Root Canal Therapy - Bicuspid		$60	$120
D3330	Root Canal Therapy - Molar		$90	$250
Periodontics				
D4210	Gingivectomy (per quadrant)		$75	$130
D4260	Osseous Surgery		$150	$280
D4341	Scaling and Root Planing (per quadrant)		$0	$25
Prosthodontics				
D5110	Complete (Upper)		$75	$145
D5130	Immediate (Upper)		$90	$165
Crown and Bridge				
D6740	Crown - Porcelain/Ceramic Substrate		$195	$240
D6750	Crown - Porcelain Fused to High Noble Metal		$160	$240
D6790	Crown - Full Cast High Noble Metal		$160	$210
Oral Surgery				
D7220	Extractions (impacted tooth; soft tissue)		$0	$50
D7230	Extractions (impacted tooth; partial bony)		$30	$70
D7240	Extractions (impacted tooth; full bony)		$40	$90
Orthodontics - Comprehensive				
D8070	Children (to age 18)		$1,750	$1,700
D8090	Adults		$1,750	$1,900
Rate Structure		**Subs**		
Employee Only		6	$21.41	$15.52
Employee + 1		4	$34.54	$31.20
Employee + Family		9	$45.00	$44.72
Monthly Premium			**$671.60**	**$620.40**
Annual Premium			**$8,059.22**	**$7,444.80**
% Change Over Current				**-7.62%**
$ Change Over Current				**-$614.42**

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Vision (Combined Pop. w/Non-Exempt Dependents) Tiered Rates

Effective: October 1, 2022

			Current		Proposed	
Carrier Name			EyeMed		Standard (EyeMed)	
Rate Guarantee			July 2023		24 months	
Plan Name			$0/$0-12/12/12-$135		Option 1	
Network			EyeMed Select	Non-Network	EyeMed Insight	Non-Network
General Plan Information						
Copay						
Examination			$0 copay	$48 reimbursed	$0 copay	$35 reimbursed
Materials			$0 copay	N/A	$0 copay	N/A
Benefit Frequency						
Examination			12 months		12 months	
Lenses			12 months		12 months	
Contacts			12 months		12 months	
Frames			12 months		12 months	
Covered Services						
Lenses						
Single Vision Lens			$0	$40 reimbursed	$0 copay	$25 reimbursed
Bifocal Lens			$0	$55 reimbursed	$0 copay	$40 reimbursed
Trifocal Lens			$0	$75 reimbursed	$0 copay	$55 reimbursed
Standard Progressive			$65 copay	$70 reimbursed	$0 copay	Not covered
Contact Lenses						
Fit-and-Follow-Up			Up to $40 copay	Not covered	Up to $40 copay	Not covered
Medically Necessary			$0	$250 reimbursed	$0 copay	$200 reimbursed
Elective			$135 allowance	$125 reimbursed	$150 allowance	$120 reimbursed
Frames			$135 allowance	$125 reimbursed	$150 allowance	$75 reimbursed
Rate Structure	**Subs**	**Subs**	**Exempt**	**Non-Exempt**	**Exempt**	**Non-Exempt**
Employee Only	7	31	$12.48	$4.98	$7.10	$7.10
Employee + 1	3	2	$12.48		$13.42	$13.42
Employee + Family	12	13	$12.48		$19.52	$19.52
Monthly Premium			**$274.56**	**$154.38**	**$324.20**	**$500.70**
Combined Monthly Premium			**$428.94**		**$824.90**	
Annual Premium			**$5,147.28**		**$9,898.80**	
% Change Over Current					**92.31%**	
$ Change Over Current					**$4,751.52**	

*Providing coverage to the General Group for Employee Dependents - not previously covered. Employer pays 100% of cost for Employees and Dependents.

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Group Life and AD&D

Effective: October 1, 2022

	Current	Proposed
Carrier Name	**Minnesota Life**	**Standard**
Rate Guarantee	July 2024	3 years
Plan Name	Group Life	GL Plan 6
Life-AD&D Benefits		
Class 1: Non-Exempt		
ADM, MGMT	$50k	$100k
SUP, TI	$35k	$100k
CLK	$20k	$100k
Class 2: Exempt		
EXEC	$50k	$100k
Guaranteed Issue		
All Classes	100%	100%
Plan Features		
Air Bag	Lesser of 10% or $10k	Lesser of 10% or $10k
Career Adjustment	Lesser of 5% or $5k	$5k/yr, up to lesser of $10k or 25% of AD&D benefit
Child Care	Lesser of 12% or $5k or actual incurred expense	$5k/yr, up to lesser of $10k or 25% of AD&D benefit
Higher Education	Lesser of 5% or $5k	$5k/yr for 4 years, up to $20k or 25% of AD&D benefit
Repatriation of Remains	Up to $5k	Up to $5k
Seat Belt	Lesser of 10% or $10k	Lesser of 10% or $10k
Traumatic Brain Injury	Lesser of 1% of your amount of insurance or 1% of diff between insurance amount and schedule of benefits	Not Included, but can include upon request
Reduction of Benefits Schedule		
Age 65	No reduction	Reduced by 35%
Age 70	Reduced by 35%	Reduced by 50%
Age 75	Reduced by 55%	Reduced by 65%
Age 80	Reduced by 70%	No further reduction

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Group Life and AD&D

Effective: October 1, 2022

	Current	Proposed
Rate Structure		
Group Life Volume	$2,800,000	$7,500,000
Premium Rate (Basic Life) per $1,000	$0.076	$0.068
Premium Rate (AD&D) per $1,000		$0.018
Monthly Premium	$212.24	$645.00
Annual Premium	$2,546.88	$7,740.00
% Change Over Current		**203.90%**
$ Change Over Current		**$5,193.12**

* Calculated from bi-weekly premiums

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Voluntary Life and Voluntary AD&D

Effective: October 1, 2022

	Current		Proposed	
Carrier	Minnesota Life		Standard	
Rate Guarantee	July 2024		3 years	
Voluntary Life and AD&D			Plan 8	
Employee	Up to $700,000 in increments of $10,000		Increments of $10k up to $700k	
Spouse	Up to $250,000 in increments of $10,000		Increments of $5k up to $250k	
Child	$20,000		Increments of $10k up to $20k	
Guaranteed Issue				
Employee	$250k		$150k	
Spouse	$50k		$50k	
Child	$20k		$20k	
Age Reduction				
65 - 69	No reduction		Reduced by 35%	
70 - 74	Reduced by 65%		Reduced by 50%	
75 - 79	Reduced by 45%		Reduced by 65%	
80 +	Reduced by 30%		No further reduction	
AD&D Rate (per $1,000)	**Employee**	**EE + Fam**	**EE/Sp.**	**Child**
Employee, Spouse, Child	$0.0200	$0.0300	$0.020	$0.030
Rate Structure (per $1,000)	**Employee**	**Spouse**	**Employee**	**Spouse**
Under 20	$0.040	$0.053	$0.030	$0.030
20 - 24	$0.040	$0.053	$0.030	$0.030
25 - 29	$0.040	$0.053	$0.030	$0.030
30 - 34	$0.053	$0.064	$0.030	$0.030
35 - 39	$0.059	$0.074	$0.040	$0.040
40 - 44	$0.066	$0.095	$0.070	$0.070
45 - 49	$0.056	$0.148	$0.100	$0.100
50 - 54	$0.151	$0.223	$0.180	$0.180
55 - 59	$0.283	$0.413	$0.270	$0.270
60 - 64	$0.436	$0.625	$0.270	$0.270
65 - 69	$0.837	$1.208	$0.380	$0.380
70 - 74	$1.359	$1.696	$1.180	$1.180
75 - 79	$1.359	$1.696	$1.180	$1.180
80 - 84	$1.359	$1.696	$1.180	$1.180
Optional Life - Child	$0.100		$0.100	

* Calculated from bi-weekly premiums

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Disability

Effective: October 1, 2022

	Current	Proposed
Carrier Name	**MetLife**	**Standard**
Rate Guarantee	July 2024	3 years
Plan Name	STD	STD Option 6
General Plan Information		
Elimination Period	7 days	7 days
Benefit Percentage		
Non-Exempt	55%	60%
Exempt	55%	60%
Maximum Weekly Benefit		
Non-Exempt	$1,357	$1,540
Exempt	$1,934	$1,853
Maximum Period of Payment		
Non-Exempt	365 days	365 days
Exempt	180 days	180 days
Rate Structure		
Total Volume	$70,698	$75,399
Premium Rate (per $10)	$0.935	$0.398
Total Monthly Premium	**$6,610.26**	**$3,000.88**
Total Annual Premium	**$79,323.16**	**$36,010.56**
% Change Over Current		**-54.60%**
$ Change Over Current		**-$43,312.59**

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Disability

Effective: October 1, 2022

	Current	Proposed
Carrier Name	**MetLife**	**Standard**
Rate Guarantee	1/1/2023	1/1/2025
Plan Name	LTD	LTD Plan 9
General Plan Information		
Elimination Period		
Non-Exempt	N/A	180 days
Exempt	180 days	180 days
Benefit Percentage	60%	60%
Maximum Monthly Benefit		
Non-Exempt	N/A	$10,000
Exempt	$10,000	$10,000
Maximum Benefit Period	SSNRA	SSNRA
Own Occupation Period	24 months	24 months
Pre-Existing Condition Limitations	3/12	3/12
Rate Structure		
LTD Volume	$289,673	$576,559
Premium Rate (per $100)	$0.240	$0.310
LTD Monthly Premium	$695.22	$1,787.33
LTD Annual Premium	$8,342.58	$21,447.99
% Change Over Current		**157.09%**
$ Change Over Current		**$13,105.41**

Rate Structure		
Total Monthly Premium	$7,305.48	$4,788.21
Total Annual Premium	$87,665.74	$57,458.56
% Change Over Current		**-34.46%**
$ Change Over Current		**-$30,207.18**

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Employee Assistance Program

Effective: October 1, 2022

		Current	Proposed
Carrier Name		**Professional Resources**	**Standard**
Plan Name		5-visit EAP	EAP
Rate Guarantee		July 2023	3 years
Schedule of Benefits			
Number of Face-to-Face Visits			3 visits included at no cost
5 visits (PEPM)		Current	N/A
6 visits (PEPM)		N/A	$0.25 PEPM
Rate Structure	**Subs**	**5 Visits**	**6 Visits**
Monthly Premium	68	$100.00	$17.00
Annual Premium		**$1,200.00**	**$204.00**
% Change Over Current			**-83.00%**
$ Change Over Current			**-$996.00**

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COBRA Administration

Effective: October 1, 2022

	Proposed
Carrier	**Igoe**
Rate Guarantee	12/31/2025
Customer Service	
Assigned Account Manager	Included
24 Hour Access for Enrollment	Included
Toll Free Number	(800) 633-8818
Service Center Hours	M-F, 8am - 5pm PST
Administration	
New Hire Notices	Included
Qualifying Events	Included
ACH Premium Transfer to Client	Included
Eligibility Reporting	Included
Premium Disbursement to Carrier	Not included
Annual Open Enrollment Packet	Included
Annual Rate Change Notices	Included
Open Enrollment Suite	$10 per enrolled/pending COBRA Member ($200 minimum)
Initial Set Up Fees	
Implementation	$0
Minimum Set Up Fees	$0
Monthly Fee Options	
PEPM fee (based on 68 Employees)	$0.75 PEPM
Flat Monthly/Annual Fee	N/A
Takeover Fees	$10 per notice
Minimum Monthly Fees	$75
Renewal Fee	N/A
Other Charges	
Midyear plan termination charge	$0
End-of-plan-year termination charge	$0
Rate Structure	
Total Monthly Premium (Includes OE cost)	$275.00
Total Annual Premium	$3,300.00

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FMLA

Effective: October 1, 2022

	Current	Proposed
Carrier	**MetLife**	**The Standard**
Rate Guarantee	July 2023	3 years
Customer Service		
Assigned Account Manager	Included	Included
FMLA Case Manager	Included	Included
Toll Free Number	(877) 638-8269	(866) 756-8116
Service Center Hours	Unknown	24 hours per day, 7 days per week
Administration		
Standard Onboarding with HR staff	Included	Included
Compliance with Fed & State regulations	Included	Included
Monthly status reports	Included	Included
Real-time updates with HR staff	Included	Included
Initial Set Up Fees		
Administration Set-Up fees	N/A	N/A
Monthly Fee Options		
PEPM Fee (based on 68 FTE)	3.49 PEPM	$3.00 PEPM
Minimum Monthly Fee	N/A	N/A
Optional Services Available		
Midyear plan termination	N/A	N/A
End-of-year termination charge	N/A	N/A
Employer portal access (under 300 EE's)	Included	Included
Rate Structure		
Total Monthly Premium	$237.32	$204.00
Total Annual Premium	$2,847.84	$2,448.00
% Change Over Current		**-14.04%**
$ Change Over Current		**-$399.84**

Additional a la carte services		
Health Advocacy Solution		$1.00 PEPM
Monthly Premium (68 FTE)		$68.00
Annual Premium		**$816.00**
ADAAA Accommodation Services		$1.00 PEPM
Monthly Premium (68 FTE)		$68.00
Annual Premium		**$816.00**

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FSA Administration

Effective: October 1, 2022

	Proposed
Carrier	Igoe
Rate Guarantee	12/31/2025
Customer Service	
Assigned Account Manager	Included
24 Hour Access for Enrollment	Included
Toll Free Number	(800) 633-8818
Service Center Hours	M-F, 8am - 5pm PST
Administration	
Non-discrimination testing	Included
5500 preparation assistance	Not Included
Section 125 POP	Included
Onsite or virtual meetings/benefit fairs	$300 per day + travel Waived if within 100 miles of Igoe's San Diego corporate facility
Standard enrollment materials	Included
Plan document amendments	Included
Initial Set Up Fees	
Implementation	Waived if implementing more than 90 days prior or post 1/1
Minimum Set Up Fees	$0
Monthly Fee Options	
PEPM fee (based on 68 Employees)	$4.90 PEPM
Flat Monthly/Annual Fee	N/A
Takeover Fees	$0
Minimum Monthly Fees	$100
Renewal Fee	N/A
Optional Services Available	
FSA plan 2% grace period provision	N/A
Travel for Meetings	None
IRS-mandated doc amendment	$100
Midyear plan termination charge	None
End-of-plan-year termination charge	None
Rate Structure	
Total Monthly Premium (based on 68 FTE)	$333.20
Total Annual Premium	$3,998.40