



Medical Plan Options

CALIFORNIA **2021**



This is a brief overview of in-network benefits. See plan documents for details.
In the unlikely event of a discrepancy between this summary and the plan documents, the plan documents will prevail.

PLAN	Local+ IN \$5,900 HDHP	Local+ IN \$4,500	Open Access+ \$4,500 HDHP	Open Access+ \$2,500	Open Access+ IN \$1,000	Open Access+ \$750	Open Access+ \$250
COVERAGE TYPE	EPO HDHP	EPO	PPO HDHP	PPO	EPO	PPO	PPO
CALENDAR YEAR DEDUCTIBLE*	\$5,900	\$4,500	\$4,500	\$2,500	\$1,000	\$750	\$250
OUTPATIENT (Employee Pays)							
Preventive Benefits	\$0 <small>DW</small>	\$0 <small>DW</small>	\$0 <small>DW</small>	\$0 <small>DW</small>	\$0 <small>DW</small>	\$0 <small>DW</small>	\$0 <small>DW</small>
Office Visits	30%	\$35 copay <small>DW</small>	20%	\$30 copay <small>DW</small>	\$25 copay <small>DW</small>	\$35 copay <small>DW</small>	\$20 copay <small>DW</small>
Specialist Visits	30%	\$70 copay <small>DW</small>	20%	\$50 copay <small>DW</small>	\$50 copay <small>DW</small>	\$60 copay <small>DW</small>	\$20 copay <small>DW</small>
OTHER SERVICES (Employee Pays)							
In-Network Coinsurance	30%	30%	20%	30%	20%	30%	10%
Maximum Out-of-Pocket	\$6,550	\$6,350	\$6,350	\$6,350	\$5,850	\$5,000	\$3,000
Rx (Employee Pays)							
Deductible	combined w/med	\$0	combined w/med	\$0	\$0	\$0	\$0
Tier 1	30%	\$15 copay	20%	\$15 copay	\$15 copay	\$20 copay	\$10 copay
Tier 2	40%	\$50 copay	20%	\$30 copay	\$30 copay	\$40 copay	\$20 copay
Tier 3	50%	30%	20%	\$50 copay	\$45 copay	30%	\$35 copay

* Calendar Year Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. All services are subject to the deductible unless otherwise noted by DW (deductible waived).

DW = The full cost of the services for MD Live Telemedicine Visits is shown. For these visits, you do not need to satisfy your calendar year deductible first. You just pay the amount of the copay at the time of service. The amount paid applies toward meeting the deductible.

Rates

PLAN	Local+ IN \$5,900 HDHP	Local+ IN \$4,500	Open Access+ \$4,500 HDHP	Open Access+ \$2,500	Open Access+ IN \$1,000	Open Access+ \$750	Open Access+ \$250
COVERAGE TYPE	EPO HDHP	EPO	PPO HDHP	PPO	EPO	PPO	PPO
TOTAL MONTHLY PREMIUM**							
Employee Only	\$311	\$393	\$408	\$559	\$565	\$590	\$725
Employee + Spouse	\$866	\$1,039	\$1,075	\$1,468	\$1,492	\$1,558	\$2,017
Employee + Child(ren)	\$750	\$902	\$932	\$1,279	\$1,296	\$1,353	\$1,745
Employee + Family	\$1,220	\$1,463	\$1,513	\$2,071	\$2,100	\$2,198	\$2,840

** Figures represent full monthly premiums without employer subsidy applied.

Dental	PLAN OPTIONS*			
	COVERAGE TYPE	PPO		HMO
		In-Network	Out-of-Network	In-Network Only
Deductible	\$50 x3 (max)	\$50 x3 (max)	None	
Preventive Care	No Charge	20% after deductible	see fee schedule	
Basic Restorative Care	20% after deductible	40% after deductible	see fee schedule	
Major Restorative Care	50% after deductible	60% after deductible	\$130 +up (see fee schedule)	
Orthodontics	Not Covered	Not Covered	\$1,220 +up (child) \$1,720 +up (adult)	
Annual Maximum Benefit	\$1,500	\$1,000	N/A	

Dental	MONTHLY RATES		
	COVERAGE TYPE	PPO	HMO
Employee		\$49.65	\$14.92
Employee + Spouse		\$101.31	\$29.84
Employee + Child(ren)		\$106.80	\$29.84
Employee + Family		\$162.33	\$48.50

* HMO Dental may not be available in all areas.

Vision	PLAN OPTION**		
	COVERAGE TYPE	PPO	
		Frequency	In-Network
Routine Eye Exam	12 months	\$10	Up to \$45 allowance
Materials Copay	12 months	\$10	N/A
Eyeglass Lenses Allowance	12 months	Covered 100% after copay	Up to \$32 (single) Up to \$80 (lenticular)
Frame Retail Allowance	24 months	Up to \$130	Up to \$71
Contact Lens Allowance (in lieu of eyeglass lenses and frames)	12 months	Up to \$150	Up to \$120

Vision	MONTHLY RATES	
	COVERAGE TYPE	PPO
Employee		\$11.14
Employee + Spouse		\$22.24
Employee + Child(ren)		\$22.47
Employee + Family		\$35.88

** Additional discounts on in-network services/accesories/additional pairs of glasses are detailed in the plan summary.

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