MSC Election Form

Anthem Blue Cross Options for 2015-16 Benefit Plan Year (Oct. - Sept.)

Brief Summary of Benefits	GROUP # 40453A	GROUP # 40453E	GROUP # 40453B	GROUP # 40453C	GROUP # 40453D
Inpatient Hospital (prior authorization required) Room, Board & Support Service	100%	100%	90%	80%	90%
Ambulance (ground or air)	100%	100%	90%	80%	90%
Emergency Room (non-emergency) Facility and Professional Expenses	$100 co-pay (waived if admitted) 100%	$100 co-pay (waived if admitted) 100%	$100 co-pay (waived if admitted) 90%	$100 co-pay (waived if admitted) 80%	$100 co-pay (waived if admitted) 90%
Well Baby/Child Preventive Care Routine physical exam/immunizations	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%
Routine Preventive Care Employee & Spouse/Domestic Partner	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%
Physical Medicine (some limits may apply) (physical therapy, occupational therapy, chiropractic)	100%	100%	90%	80%	90%
Scans: CT, CAT, MRI, PET etc.	100%	100%	90%	80%	90%
Diagnostic, X-ray & Laboratory Procedures	100%	100%	90%	80%	90%
Psychiatric & Substance Abuse					
Inpatient Care:Facility based care(preauthorization required)	100%	100%	90%	80%	90%
Outpatient Care:Facility based care(preauthorization required)	Deductible Waived office visit co-pay applies	Deductible Waived office visit co-pay applies	Deductible Waived office visit co-pay applies	Deductible Waived office visit co-pay applies	90%
Brief Summary of Out-of-Pocket Expenses					
•Office Visits	**$0 co-pay**	**$20 co-pay**	**$20 co-pay**	**$20 co-pay**	**90%**
•Individual / Family Deductible(s) A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan - Deductibles are per calendar year.	**$100 per individual $300 family**	**$100 per individual $300 family**	**$100 per individual $300 family**	**$300 per individual $600 family**	**$3000 per individual $5200 family**
•Individual / Family - Out of Pocket Max (OOP Max) The OOP Max is the most you have to pay in deductibles, co-insurance and co-pays for covered health services during a calendar year. **All deductibles, co-insurance and co-pays apply to the calendar year OOP maximum.**	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$5000 per individual $10,000 family**

Outpatient Prescription Drugs

	Network	Costco			Network	Costco			Network	Costco			Network	Costco			Network	Costco		
	Walk-in	Walk-in		Mail	Walk-in	Walk-in		Mail	Walk-in	Walk-in		Mail	Walk-in	Walk-in		Mail	Walk-in	Walk-in		Mail
Days supply	30	30	90	90	30	30	90	90	30	30	90	90	30	30	90	90	30	30	90	90
Generic Cost	$9	Free	Free	Free	$9	Free	Free	Free	$9	Free	Free	Free	$9	Free	Free	Free	$7	Free	Free	Free
Brand Name Cost	$35	$35	$90	$90	$35	$35	$90	$90	$35	$35	$90	$90	$35	$35	$90	$90	$25	$35	$90	$90
Out-of-Pocket Maximum	**$2500 individual $3500 family**				**$2500 individual $3500 family**				**$2500 individual $3500 family**				**$2500 individual $3500 family**				**Medical and RX are combined in the OOP Max above**			

This sheet is only a brief summary of benefits that reflects in-network benefits. Please review the benefit plan booklets and summaries, located on SharePoint (click on the Human Resources link, then Benefits), for limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

Rx subject to deductible (The deductible must be met prior to the plan paying as indicated above and prior to receiving the $0 co-pay Costco RX Benefit).

MSC Election Form

Anthem Blue Cross Options for 2015-16 Benefit Plan Year (Oct. - Sept.)

	GROUP # 40453A	GROUP # 40453E	GROUP # 40453B	GROUP # 40453C	GROUP # 40453D
Medical / RX / Behavioral Monthly Cost	$1,314.00	$1,268.00	$1,227.00	$1,118.00	$817.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	$1,463.35	$1,417.35	$1,376.35	$1,267.35	$966.35
TOTAL COST w/ Delta Dental PPO Plan	$1,450.35	$1,404.35	$1,363.35	$1,254.35	$953.35
Employer Contribution/Monthly	$991.67	$991.67	$991.67	$991.67	$991.67
10 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$566.02**	**$510.82**	**$461.62**	**$330.82**	**-$30.38**
Employee's Cost/Monthly with Delta Dental PPO	**$550.42**	**$495.22**	**$446.02**	**$315.22**	**-$45.98**
11 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$514.56**	**$464.38**	**$419.65**	**$300.74**	**-$27.62**
Employee's Cost/Monthly with Delta Dental PPO	**$500.38**	**$450.20**	**$405.47**	**$286.56**	**-$41.80**
12 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$471.68**	**$425.68**	**$384.68**	**$275.68**	**-$25.32**
Employee's Cost/Monthly with Delta Dental PPO	**$458.68**	**$412.68**	**$371.68**	**$262.68**	**-$38.32**

Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee

Vision Plan: Vision Service Plan

$15.00 Co-pay

The plan provides coverage for covered services and/or materials when you go to a participating provider for:

- One comprehensive examination every calendar year
- One pair of standard lenses every calendar year
- One standard frame every other calendar year or
- One pair of contact lenses every other calendar year

Term Life & Accidental Death & Dismemberment Insurance

$50,000 paid by Sun Financial Company to all full-time, active regular employees working a minimum of 20 hours each week.

Dental Plan: Delta Dental Premier/Incentive Plan

Under this program, Delta pays 70% of the approved fees for covered diagnostic, preventive, cast and crown benefits during the first year you are eligible. This percentage will increase 10% each year (to a maximum of 100%) for each employee, provided you visit the dentist at least once during the year. The maximum benefit paid per calendar year is $2,200 per person (as long as the dentist is in the network).

Dental Plan: Delta Dental PPO

Under this plan, Delta pays 100% providing the dentist is a PPO network dentist. This plan covers diagnostic & preventive, crowns, and other basic services. The maximum benefit paid per calendar year is $2,000 per person. Note: Members may change from the PPO to the Premier/Incentive plan during open enrollment. If they make this change, their incentive plan level will start at 70% for the employee and all dependents.

MSC Election Form

Kaiser Option for 2015-16 Benefit Plan Year (Oct. - Sept.)

Brief Summary of Benefits	***Member Pays:***
Professional Services	
Office visit co-pay	$10
Urgent care co-pay	$10
Specialists/Consultants co-pay	$10
Prenatal, postnatal office visit co-pay	$0
Scans: CT, CAT, MRI, PET, ect.	$0
Diagnostic X-ray & laboratory procedures	$0
Infertility (diagnosis/treatment of causes of infertility)	50%
Preventative care services (includes physical exams & screenings)	$0
Hospital & Skilled Nursing Facility Services	
Emergency Room (non-emergency)	$100 co-pay (waived if admitted)
Inpatient Hospital co-pay (preauthorization required)	$0
Outpatient Hospital co-pay	$10
Surgery, Outpatient (performed in an Abulartory Surgery Center)	$10
Surgery, Outpatient (performed in a Hospital)	$10
Mental Health Services & Substance Abuse Treatment	
Inpatient Care: Facility based care (preauthorization required)	$0
Outpatient Care: Facility based care (preauthorization required)	$10
Other Services	
Acupunture - Limits apply	$10 co-pay 30 visits
Ambulance (ground or air)	$50
Chiropractic - Limits apply	$10 co-pay 30 visits
Durable medical equipment (DME)	100%
Physical and occupational therapy - Limits apply	$10
•Individual / Family Deductible(s) A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan - Deductibles are per calendar year.	**$0**
•Individual / Family - Out of Pocket Max (OOP Max) - The OOP Max is the most you have to pay in deductibles, co-insurance and co-pays for covered health services during a calendar year. **All deductibles and co-pays apply to the calendar year OOP maximum.**	**$1500 per individual** **$3000 family**
Prescription Drugs	
Days supply	100
Generic Cost	$10
Brand Name Cost	$10
Mail Order	$10

This sheet is only a brief summary of benefits that reflects in-network benefits. Please review the benefit plan booklets and summaries, located on SharePoint (click on the Human Resources link, then Benefits), for limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

MSC Election Form
Kaiser Option for 2015-16 Benefit Plan Year (Oct. - Sept.)

MONTHLY COSTS	
Medical	$1,238.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	$1,387.35
TOTAL COST w/ Delta Dental PPO Plan	$1,374.35
Employer Contribution/Monthly	$991.67

10 MONTH EMPLOYEE COST	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	$474.82
Employee's Cost/Monthly with Delta Dental PPO	$459.22

11 MONTH EMPLOYEE COST	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	$431.65
Employee's Cost/Monthly with Delta Dental PPO	$417.47

12 MONTH EMPLOYEE COST	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	$395.68
Employee's Cost/Monthly with Delta Dental PPO	$382.68

Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee

Vision Plan: Vision Service Plan

$15.00 Co-pay

The plan provides coverage for covered services and/or materials when you go to a participating provider for:

- One comprehensive examination every calendar year
- One pair of standard lenses every calendar year
- One standard frame every other calendar year or
- One pair of contact lenses every other calendar year

Term Life & Accidental Death & Dismemberment Insurance

$50,000 paid by Sun Financial Company to all full-time, active regular employees working a minimum of 20 hours each week.

Dental Plan: Delta Dental PPO

Under this plan, Delta pays 100% providing the dentist is a PPO network dentist. This plan covers diagnostic & preventive, crowns, and other basic services. The maximum benefit paid per calendar year is $2,000 per person. Note: Members may change from the PPO to the Premier/Incentive plan during open enrollment. If they make this change, their incentive plan level will start at 70% for the employee and all dependents.

Dental Plan: Delta Dental Premier/Incentive Plan

Under this program, Delta pays 70% of the approved fees for covered diagnostic, preventive, cast and crown benefits during the first year you are eligible. This percentage will increase 10% each year (to a maximum of 100%) for each employee, provided you visit the dentist at least once during the year. The maximum benefit paid per calendar year is $2,200 per person (as long as the dentist is in the network).

MSC Election Form
Anthem Blue Cross Two-Tiered Anchor Bronze PPO Plan
for 2015-16 Benefit Plan Year (Oct. - Sept.)

BRIEF SUMMARY OF BENEFITS		
Inpatient Hospital (prior authorization required) Room, Board & Support Service	70%	
Emergency Room (non-emergency)	$100 co-pay	
Facility and Professional Expenses	70%	
Accident Care (48 hrs.) **Emergency Room**	$100 co-pay	
Facility and Professional Expenses	70%	
Well Baby/Child Preventive Care Routine physical exam/immunizations	Deductible Waived 100%	
Routine Preventive Care Employee & Spouse/Domestic Partner	Deductible Waived 100%	
Physical Medicine (physical therapy, occupational therapy, chiropractic)	70% (some limits may apply)	
Psychiatric & Substance Abuse		
Inpatient	70%	
Outpatient	70% (See office visit co-pays)	
BRIEF SUMMARY OF OUT-OF-POCKET EXPENSES		
Office Visits	**$60 first 3 visits** (subject to deductible)	
Individual / Family Deductible(s) - A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan. Deductibles are per calendar year.	**$5,000 per individual** **$10,000 family**	
Individual / Family - Out of Pocket Max (OOP Max) The OOP Max is the most you have to pay in deductibles, co-insurance and co-pays for covered health services during a calendar year. **All deductibles, co-insurance and co-pays apply to the calendar year OOP maximum.**	**$6,350 per individual** **$12,700 family**	
Outpatient Prescription Drugs		
Administered by medical carrier & subject to deductible	RETAIL	MAIL ORDER
Generic	$9	$18
Brand Name	$35	$90
Days supply	30	90

COSTS	Employee	Employee + Child(ren)
Medical Monthly Cost	$477.00	$749.00
Administrative Fee	$4.25	$4.25
Employer Contribution/Monthly	-$991.67	-$991.67
Total Costs/Monthly	-$510.42	-$238.42

10 MONTH EMPLOYEE COST	**Employee**	**Employee + Child(ren)**
	-$612.50	-$286.10

11 MONTH EMPLOYEE COST	**Employee**	**Employee + Child(ren)**
	-$556.82	-$260.09

12 MONTH EMPLOYEE COST	**Employee**	**Employee + Child(ren)**
	-$510.42	-$238.42

Employees enrolled in this plan may not enroll into SISC dental and vision or participate in the employer paid life insurance through Sun Life.

This plan is for employee and employee's dependent child(ren) to age 26 only. Spouses or domestic partners are not eligible to participate in this plan.

*By electing this plan, you certify that you understand you are eligible to participate in the **medical plan only** and you are not eligible to enroll in dental, vision or life insurance. You also acknowledge this plan has no enrollment option for spouse or domestic partner.*

Employee ☐ **Employee + Child(ren)** ☐

Print Name

Sign Name

Date **Social Security Number**